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BOARD OF HEALTH

REPORT No. 14

FOR CONSIDERATION BY THE COUNCIL OF THE CORPORATION OF THE CITY OF TORONTO ON NOVEMBER 12, 1990.

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BOARD OF HEALTH

REPORT No. 14

FOR CONSIDERATION BY THE COUNCIL OF THE CORPORATION OF THE CITY OF TORONTO ON NOVEMBER 12, 1990.

1

IMMIGRATION REQUIREMENTS FOR HIV INFECTED PERSONS ATTENDING THE VII INTERNATIONAL CONFERENCE ON AIDS IN FLORENCE, ITALY, JUNE 1991

The Board of Health recommends:

1. **That the Department of Public Health support the attendance of conference visitors at the VII International Conference on AIDS in Florence, Italy, June 1991; and**
2. **That the Department of Public Health contact the appropriate authorities in six months to ensure that the same immigration requirements are in place.**

The Board of Health submits the report (October 12, 1990) from the Medical Officer of Health:

Origin: Medical Officer of Health, October 3, 1990 (c34hlth90120:199)

Recommendations:

1. It is recommended that the Department of Public Health support the attendance of conference visitors at the VII International Conference on AIDS in Florence, Italy, June 1991.
2. That the Department of Public Health contact the appropriate authorities in six months to ensure that the same immigration requirements are in place.

Background: At its meeting on September 13, 1990 the Board of Health requested the Medical Officer of Health to report on the Italian Immigration policy vis-a-vis travellers infected with HIV. At the previous conference in San Francisco, representation from the City of Toronto Department of Public Health was absent in response to the U.S. policy which restricted entry of infected travellers. Both the Federal Centre for AIDS and the Italian Embassy in Ottawa have informed the Department that, at the present time, there are no travel restrictions in place for HIV infected persons visiting Italy.

The Board of Health also submits the communication (October 3, 1990) from The Honourable Perrin Beatty, Minister of National Health and Welfare:

Thank you for your letter, in which you express your concern, and that of the City of Toronto Board of Health, over what you deem to be a discriminatory application of Canada's immigration policy vis-a-vis travellers infected with HIV. Please excuse the delay in replying.

AIDS is a disease that, with few exceptions, is acquired by either intravenous drug abusers or those who expose themselves to HIV infection through sexual contact. It is a disease for which there is no known cure but for which there are clearly-established precautions that can be taken to prevent infection.

I believe that the present immigration policy related to travellers to Canada who are infected with HIV is unnecessarily restrictive and serves no useful purpose in the control of this communicable disease. In this regard, the Department of Employment and Immigration has conducted a review of the medical inadmissibility criteria of the Immigration Act. The conclusions and recommendations from this review process are expected in the near future.

You might note that prominent bodies, such as the World Health Organization, the Department of Health and Human Resources of the United States and many Canadian public health organizations share my views on the subject.

I believe that emphasis must be given to wide-ranging health education programs, including the dissemination of information relating to the means by which this disease can be prevented from spreading.

I would like to thank you and the members of the Board for bringing you concerns regarding AIDS to my attention and I hope that these observations have answered your concerns.

2

TORONTO COMMUNITY HEALTH SURVEY 1988 - REPORTS NOS. 1-5

The Board of Health received the report (August 31, 1990) from the Medical Officer of Health and forwards same to Council for information.

Ms. Joyce Bernstein, Department of Public Health, gave a slide presentation.

The Board of Health extended thanks to staff of the Department of Public Health for the presentation and the written reports.

1988 Toronto Community Health Survey Reports Nos. 1-5 have been forwarded to Members of Council and are on file in the City Clerk's Department.

The Board of Health submits the report (August 31, 1990) from the Medical Officer of Health:

Origin: Medical Officer of Health, August 31, 1990 (c34hlth90102:90)

Recommendation: That the Board receive the 1988 Community Health Survey - Reports numbered 1 through 5 for information.

Comments: Distributed to Members of the Board under separate cover, and available to the public on request, are the first five of ten reports prepared from data collected in the 1988 Toronto Community Health Survey (TCHS88). The remaining five reports are currently in production and will be available later in 1990.

The first extensive survey of the health status and related health risks and behaviours of Toronto residents by the Department of Public Health was carried out in 1983. The database generated from this first Toronto Community Health Survey (TCHS83) provided information specific to City residents which was unavailable from other sources. These data have been used by staff throughout the Department in the preparation of conference presentations, grant proposals, and a variety of reports requiring Toronto-specific information. In addition, many of the information requests to the Department from community groups and other organizations within the City have been answered through use of TCHS83 data. It was the Department's intention to repeat the study after five years.

In 1988 the second study (TCHS88) was undertaken. As in the 1983 study, nearly 1,000 Torontonians were interviewed by telephone; selected at random by an established telephone survey method known as "random digit dialling". The objectives of this second study were: (1) to update the information collected five years previously; (2) to conduct comparisons where possible with the 1983 data; (3) to help detect emerging trends in health issues; and (4) to provide information on new issues not identified in the 1983 study.

The report format for the 1988 survey is different from the earlier edition. In place of one comprehensive report, a series of ten subject reports will be produced. The selection of the individual topics corresponds (to the extent possible) with current Departmental priorities for policy and program development (Reports #3, 4, 6, 8 and 9). Other areas of major programming are also included (Reports #2, 5 and 7) with a separate report on the study methods used (Report #1). It is intended as an economy measure that researchers and other readers need only request those reports in which they are interested. This modular format also permits earlier publication of a large portion of the information collected.

The report topics for the 1988 Toronto Community Health Survey and a brief synopsis of those being released at this time are as follows.

Report #1 - Introduction and Methods

This report provides details of the methods used in the development, data collection and data analysis of the 1988 survey. Issues such as sample representation and non-response bias are also examined. Many comparisons and references are made to the 1983 results. Highlights of this report are summarized in an abstract which serves as the introduction to each of the other reports of the series.

Report #2 - Seniors

The responses of the 101 senior citizens interviewed for the TCHS88 provide the basis for the report. Topics explored include self-assessed health status, activity limitations, mental health, preventive health practices and retirement. Specific areas of concern identified in this document include the prevalence of activity limitations among the elderly as well as indications of relatively widespread use of sleeping pills and tranquilizers.

Report #3 - Chemicals and Toxins

This report describes the environmental concerns expressed by respondents. Sixty-one percent of those interviewed were 'somewhat' or 'very' dissatisfied with the quality of Toronto's environment; specific areas of concern are explored. In addition, 59% of respondents reported using insecticides or pesticides in or around their homes in the past year and 26% of working respondents reported occupational exposures to dangerous conditions or substances.

Report #4 - Healthy Parents/Healthy Children

This report addresses several issues involving the well-being of parents. Of the 405 parents responding to the survey, 78% were very satisfied with their relationship with their children. Topics explored include the use of, and satisfaction with, child care arrangements and the use of child restraints in cars.

Report #5 - Healthy Sexuality

The final report released at this time summarizes the results of questions concerning the precautions used by sexually active respondents with respect to protection from sexually transmitted disease and methods of birth control. Based upon the pretest experience prior to the survey, these questions were asked of only those individuals up to and including age 50. Ninety percent of male respondents and 85% of females reported they had been sexually active in the past five years. Approximately 70% of those with two or more partners during this time felt they were protecting themselves from STD; most respondents who were not protecting themselves felt they were with a partner who did not put them at risk. This report also examines the methods of protection used as well as factors associated with this use.

Forthcoming reports are:

Report #6	-	Substance Abuse
Report #7	-	Mental Health
Report #8	-	Cancer and Heart Disease
Report #9	-	Multiculturalism and Advocacy for the Basic Prerequisites to Health

Report #10 - Nutrition, Exercise, Safety, and Dental Health

Finally, as a general survey method, telephone surveys of this type have been found to be of much more limited value than they were even five years ago and much more difficult to conduct, as discussed in Report #1. For a number of reasons it is unlikely that the Department will undertake a similar large scale comprehensive telephone health survey in the future. However, analyses such as those appearing in this report series will be carried out using information from a variety of sources including the new Ontario Health Survey, which is a household interview, and research efforts of the Department that will focus more in the 1990s on selected populations, such as the homeless and specific ethnocultural groups in Toronto.

3

RESPONSE TO "STRATEGIES FOR CHANGE" - COMPREHENSIVE REFORM OF ONTARIO'S LONG-TERM CARE SERVICES

The Board of Health recommends:

1. **That the report (October 15, 1990) from the Medical Officer of Health be circulated to the Metropolitan Toronto District Health Council, the Association of Local Official Health Agencies, community groups and community service agencies for review and comment and for deputations at a future meeting of the Board of Health.**
2. **That in view of the analysis of "Strategies for Change", the Minister of Health and the Minister of Community and Social Services be requested to interrupt the implementation of the organization inherent in "Strategies for Change".**
3. **That the Board of Health recommend to the Minister of Health and the Minister of Community and Social Services the adoption of Recommendation No. 1 of "Managing the Transition":**

> **"That the Ministers establish a meaningful consultation process that will enable the provincial associations in long-term care to review "Strategies for Change" and the directions it establishes. We suggest that at least $12 million be set aside for provincial organizations and local agencies to hire planning staff; acquire management information systems; develop pilot projects; and hold conferences and seminars that will enable the sector to work together with government on creating a consensus on the component parts of the key initiatives proposed in the government's strategy document."**

4. **That the Board of Health recommend that the consultation process include a critical review of other organizational and delivery models that more closely adhere to the principles enunciated by "The Evans Report", the Premier's Council on Health Strategy and the Board of Health programmatic components for reform of the health care system.**
5. **That the Board of Health indicate support for the Department of Public Health exploring alternative pilot options in the area of coordinated long term care and approach such organizations as COSSET (Coordination of Services for Seniors in East Toronto), the East York Department of Public Health, the Toronto East General Hospital, the Wellesley Hospital and the Riverdale Hospital, to determine their interest in a partnership.**

The Board of Health advises having requested the Medical Officer of Health to prepare a letter on behalf of the Board of Health expressing the concerns of the Board regarding certain aspects of the report "Strategies for Change: Comprehensive Reform of Ontario's Long Term Care Services", particularly the lack of emphasis on disease prevention and health promotion.

The Board of Health extended thanks to Dr. Michael Rachlis, the Medical Officer of Health, staff of the Department of Public Health and all other persons who participated in the discussions during preparation of the report.

The Board of Health submits the report (October 15, 1990) from the Medical Officer of Health:

Origin: Medical Officer Health, October 15, 1990 (c34hlth90123:374)

The accompanying report reviews some issues around the organization of long-term care services (LTC) and some other policies relevant to the care of the elderly and the disabled. Next, the report reviews the overall health policy directions established for the Province and proposed by the Toronto Board of Health and the principles for reform incorporated in "Strategies for Change". The third section discusses the essential components of LTC. Finally, four models for LTC are described and rated for their consistency with the directions for health policy and the principles for reform.

Recommendations:

1. That the report be circulated to the Metropolitan Toronto District Health Council, the Association of Local Official Health Agencies, community groups and community service agencies for review and comment and for deputations at a future meeting of the Board of Health.
2. That in view of the analysis of "Strategies for Change", the Minister of Health and the Minister of Community and Social Services be requested to interrupt the implementation of the organization inherent in "Strategies for Change".
3. That the Board of Health recommend to the Minister of Health and the Minister of Community and Social Services the adoption of recommendation #1 of "Managing the Transition":

   > "That the Ministers establish a meaningful consultation process that will enable the provincial associations in long-term care to review "Strategies for Change" and the directions it establishes. We suggest that at least $12 million be set aside for provincial organizations and local agencies to hire planning staff; acquire management information systems; develop pilot projects; and hold conferences and seminars that will enable the sector to work together with government on creating a consensus on the component parts of the key initiatives proposed in the government's strategy document.

4. That the Board of Health recommend that the consultation process include a critical review of other organizational and delivery models that more closely adhere to the principles enuniciated by "The Evans Report", the Premier's Council on Health Strategy and the Board of Health programmatic components for reform of the health care system.

Background:

In May 1990 the Ministers of Health and Community & Social Services released the document "Strategies for Change: A Reform of Ontario's Long-Term Care System. Copies have previously been circulated to Board of Health members.

While there is much to praise in this document particularly the intention to expand and develop an effective community and support service system, we believe that there are many problems with the model proposed.

The accompanying document, compiled by Dr. Michael Rachlis after consultation with Board of Health members and Department of Public Health staff, represents a critical comparison of the proposed "strategies model" with previously determined sets of criteria. Some of these criteria were developed by advisory committees to the Province. The Board of Health adopted its criteria as a result of a review of the recommendations contained in Healthy Toronto 2000. The criteria represents a template against which key principles inherent in any model of long-term care programming should be compared.

The review by Dr. Rachlis compares models against this template — the long-term care model proposed in "Strategies for Change", a long-term care model as administered by local health units in Alberta and British Columbia, a sophisticated program named ONLOK from San Francisco, and a theoretical model which offers 'consumers' a degree of flexibility not available in the present systems.

In view of Dr. Rachlis' findings, the Board of Health may wish to consider two actions:

1. Circulate the document and report to community groups and service agencies (including ALOHA and MTDHC) and schedule a meeting for deputations.
2. Call upon the Ministers of Health and Community & Social Services to halt the implementation process. This action would complement the first recommendation contained in "Managing the Transition". A report to the Government of Ontario Long-Term Care Strategy. A document produced by the Ontario Coalition of Non-Profit Organizations Working with Seniors.

This recommendation reads:

> "1. That the Ministers establish a meaningful consultation process that will enable the provincial associations in long-term care to review "Strategies for Change" and the directions it establishes. We suggest that at least $12 million be set aside for provincial organizations and local agencies to hire planning staff; acquire management information systems; develop pilot projects; and hold conferences and seminars that will enable the sector to work together with government on creating a consensus on the component parts of the key initiatives proposed in the government's strategy document.

The Board of Health may wish to suggest that such a consultation process include a critical review of other organizational models such as those described in the accompanying report.

Draft Response For Toronto Board Of Health To Strategies For Change: Comprehensive Reform Of Ontario's Long-Term Care Services

by Michael M. Rachlis, MD, MSc, FRCPC

Executive Summary

The Ontario government has been planning reforms to its system of long-term care (LTC) for a number of years. In June of 1990, the government released a discussion paper, Strategies for Change: Comprehensive Reform of Ontario's Long-Term Care Services. The Province has initiated a consultation process and requested responses to their discussion paper.

What We Know About Long-Term Care

Most persons in need of long-term care are cared for in the community by family. Improving community services can reduce the demand for institutional care. In addition, the psychosocial health and functioning of those who receive enhanced community services and their caregivers are superior to that of persons who receive 'routine' community care. In general, the costs for care are slightly increased with community-based programs. Enhanced community services should be seen as relatively low cost programs which improve quality of life rather than cost saving mechanisms.

Geriatric Assessment

Comprehensive geriatric assessment can be defined as, a multidisciplinary evaluation of the patient in several domains, most commonly physical, mental, social, economic and functional, leading to coordinated care plans focusing services and interventions on the patient's problems and disabilities. Comprehensive geriatric assessment has been found to improve patient outcomes in both the institutional and community setting.

Health Promotion

Health promotion is popularly considered to be a process whereby healthy people attempt to get healthier. However, those who are at the greatest risk for developing ill health are, in fact, those most likely to benefit from health promotion. Several studies have found health promotion to reduce institutionalization and mortality in the elderly.

The Essential Functions of a Long-Term Care System

The key components of long-term care include intake, assessment, case management, service provision, and advocacy. It is essential that Province-wide standards be developed for long-term care. Further, quality assurance mechanisms should be in place before programs are established and budgets are allocated. The standards would have a direct impact on the services that would be deemed necessary for clients at different levels of need. Standards for long-term care would determine the resources needed for the system.

Conflict of Interest

"Strategies for Change" claims that it would be a conflict of interest for a service provider agency to become the Service Access Organization (SAO) which within the Province's model would be responsible for case management. The conflict of interest would exist, presumably because the provider would have an incentive to purchase services from itself and increase (inappropriately) the level of servicing. While this situation would entail a potential conflict of interest, other potential conflicts of interest exist in the health care system without apparent concern. Further, the organization of LTC services entails many other potential conflicts of interest and there are instances where organizing the system to maximize efficiency might create potential conflicts of interest.

However, one could expeditiously use various checks and balances which would control conflict of interest without sacrificing efficiency or coordination. The key mechanisms to prevent self interest from acting contrary to the overall community interest are clear Provincial-wide standards for assessment and care, a thorough quality assurance process, an accessible swift appeals process, clear lines of political accountability, and an advocacy system.

The Current Directions for Health Policy from the Province and the Board of Health

Health policies are too often developed in an ad hoc, reactive fashion. Too often principles of policy are lost within the 'crucible' of the development process. One method to prevent the oversight of principles and values is to rate proposed policies for their agreement with previously stated principles. Four models of long-term care are considered and rated for their congruence with the Ontario values for health (as found in the Report of the Ontario Health Panel), the Ontario goals for health (from the Premier's Council on Health Strategy), the principles for Ontario LTC reform (from "Strategies for Change: Comprehensive Reform of Ontario's Long-Term Care Services"), and the Board of Health's programmatic components for reform of the health care system (Report to the Board of Health, December/89).

Different Models of Long-term Care Delivery

Policy option #1	-	The model likely from Strategies for Change
Policy option #2	-	A model like one in British Columbia and parts of Alberta
Policy option #3	-	A model with full vertical integration of all service delivery and a focus on health promotion
Policy option #4	-	A model transferring resources for care to individuals who then decide which services to purchase

Consistency of four different policy options for long-term care with principles of health care reform. '—' indicates the policy is quite inconsistent, '-' somewhat inconsistent, '+ +' quite consistent, '+' somewhat consistent, ? indicates it was difficult to assess consistency.

	Policy Options			
	1	2	3	4
Values (from Evans Panel)				
1. Equity	?	?	?	?
2. Quality	?	?	?	?
3. Comprehensiveness	-	?	+	+ +
4. Informed Choice	-	?	+	+ +

5. Accountability	-	+	+	+
6. Cost-effectiveness	—	+	+ +	+
7. Commitment to the future	?	?	+	?
Goals (from Premier's Council on Health)				
1. Shift the emphasis to health promotion and disease prevention.	?	+	+ +	+
2. Foster strong and supportive families and communities.	?	?	+ +	+ +
3. Ensure a safe, high quality physical environment.	N/A			
4. Increase the number of years of good health for the citizens of Ontario by reducing illness, disability & premature death.	?	?	+	?
5. Provide accessible, affordable, appropriate health services for all.	-	+	+ +	+
Principles for reform of long-term care (from "Strategies for Change")				
1. Individualization	-	?	+	+ +
2. Independence and choice	-	?	?	+ +
3. Community living	-	?	+	+ +
4. Service accessibility	+	+	+	+
5. Support for informal caregivers	?	?	+	+ +
6. Local planning and management	-	+	+	+
7. Affordability	-	+	+ +	+
Programmatic components of reform health care system (from the Board of Health)				
1. Vertical integration of services	—	+	+ +	+
2. Reallocation of disease prevention, health promotion, & community services	-	?	+ +	+
3. Democratization of allocation and management	-	+	+	+ +
4. Informed choices to patients and families	?	?	+	+ +
5. Evaluation of new and existing services	?	?	?	?

Preamble

The Ontario government has been planning reforms to its system of long-term care (LTC) for a number of years. In June of 1990, the government released a discussion paper, "Strategies for Change: Comprehensive Reform of Ontario's Long-Term Care Services" (1). The Province has initiated a consultation process and requested responses to their discussion paper.

Defining Long-term Care

Rosalie and Robert Kane, two American health service researchers with many decades of experience in long-term care have provided lay and professional definitions of LTC. In layperson's terms, LTC is defined as:

> "...The assistance that is needed to manage as independently and as decently as possible when disabilities undermine capacities." (2)

In professional terms it is defined as:

> "...a set of health, personal care, and social services delivered over a sustained period of time to persons who have lost or never acquired some degree of functional capacity." (2)

"Strategies for Change" defines long-term care as:

> "...a range of community, personal support, and health care services required on a periodic or ongoing basis by individuals, who, because of physical disability or aging, need assistance to function as independently as possible." (1)

There are some contradictions in who is targeted for LTC. Certain mental disabilities are included but others are not. For example, an elderly person with Alzheimer's disease and behavioural problems or a young person brain damaged by a car accident is usually included in the LTC system. However, a young person with schizophrenia typically is not.

Persons dying from cancer or other terminal illnesses require the same spectrum of care to those who are more traditional recipients of LTC but they may not be included in the LTC system. Also, someone who mainly requires physicians' services to improve their function (e.g., some persons with chronic lung or heart disease) are not typically included in the LTC system.

Organization of This Report

This report for the Board of Health first reviews what we know about the organization of long-term care services (LTC) and some other policies relevant to the care of the elderly and the disabled. Next, the report reviews the overall health policy directions for the Province and the Toronto Board of Health and the principles for reform from the "Strategies for Change". The third section discusses the essential components of LTC and the possible division of responsibilities for these components. Then a model of long-term care which would best fit the principles for reform as outlined in "Strategies for Change" is discussed. Finally, four possible models for LTC are described and rates for their consistency with the directions for health policy and the principles for reform.

I. What We Know About Long-term Care

Ia. Community Care For The Elderly

Most persons in need of long-term care are cared for in the community, not in institutions. Improving community services can reduce the demand for institutional care. Professor Bill Weissert of the University of Michigan has recently reviewed over two dozen controlled studies which investigated the impact of enhancing community services (3). In almost all of these studies it was demonstrated that if community services were improved people were less likely to enter an institution. These studies also show:

- The psychosocial health and functioning of those who receive enhanced community services are superior to that of persons who receive 'routine' community care.
- Enhancing community services improves psychosocial health and functioning of the family caregivers.
- Enhancing community services appears to do little to improve physical health and function.
- Although there are some examples of where enhancement of community services has reduced the overall costs for care (e.g., the On Lok program described below), in the main, the costs for care are slightly increased for community-based programs. Professor Weissert adds that community services should be advocated as relatively low-cost programs which improve quality of life rather than cost saving mechanisms.

Ib. Geriatric Assessment

A recent review of the quality of medical care received by the elderly concluded, "...there are problems in the quality of care received by older persons in ambulatory, hospital, and nursing home settings." (4) Although this review primarily used American studies there is no reason to believe that the conclusions don't apply to Canada.

With such concerns about the quality of health care received by older persons, some investigators have studied the impact of providing specialized assessment and rehabilitative services to this population. A recent United States National Institute of Health conference defined comprehensive geriatric assessment as, a multidisciplinary evaluation of the patient in several domains, most commonly physical, mental, social, economic and functional, leading to coordinated care plans focusing services and interventions on the patients problems and disabilities (5).

Comprehensive geriatric assessment has been found to improve patient outcomes in both the institutional (6,7,8) and community setting (9). Comprehensive geriatric assessment has not been found to necessarily benefit all older persons (10), but it is generally felt that it improves patient outcomes and reduces future institutional use when applied to "at-risk" elderly. The scientific literature on geriatric assessment indicates that it would likely benefit persons who are being considered for institutional placement. Dr. William Dalziel, a geriatrician from Ottawa, has suggested that inadequate assessment leads to a "crisis intervention approach in the care of the elderly." (11)

Ic. Health Promotion And The Elderly

Health promotion is popularly considered to be a process whereby healthy people attempt to get healthier. However, those who are at the greatest risk for developing ill health are, in fact, those most likely to benefit from health promotion. The World Health Organization has defined health promotion as:

> "Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental, and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing." (12)

Some studies have found health promotion to reduce institutionalization and mortality in the elderly. A randomized study in Wales found that the use of health visitors increased the use of services and reduced mortality for the elderly patients on the lists of general practitioners (13). A Danish randomized study found that regular home visiting by nurses to older persons reduced mortality and rates of acute and chronic institutionalization (14). Recently, a randomized study done in New Westminster, British Columbia found that adding a health promotion component (administered by a nurse) to the present long-term care assessment process could markedly reduce the need for institutional services over 21 months of follow-up (15).

II. The Current Directions For Health Policy From The Province And The Board of Health

Health policies are too often developed in an ad hoc, reactive fashion. Too often principles of policy are lost within the 'crucible' of the development process. One method to prevent the oversight of principles and values in the policy development process is to rate proposed policies for their agreement with previously stated principles. This section of the report reviews the Ontario values for health (as found in the Report of the Ontario Health Panel), the Ontario goals for health (from the Premier's Council on Health Strategy), the principles for Ontario LTC reform (from "Strategies for Change: Comprehensive Reform of Ontario's Long-Term Care Services"), and the Board of Health's programmatic components for reform of the health care system (Report of Dr. Michael Rachlis to the Board of Health, December/89).

IIa. The Ontario Health Review Panel (Evans Report)

The Evans Report (16) elaborated seven 'key principles' or 'fundamental values' to guide new policy direction:

1. "Equity. Each individual has equal opportunity to attain good health and to have access to appropriate health care services.
2. "Quality. Health care is concerned with the quality of life, which emphasizes adding "life to years", not just "years to life". Health care is also devoted to quality of care which implies a competent and considerate provision of care.

3. "Comprehensiveness. The health care system includes a broad spectrum of activities directed to health promotion, disease prevention, illness diagnosis, treatment and rehabilitation and the development of coordinated health policy. The system also encourages continuity and flexibility among the various parts.

4. "Informed Choice. The individual is entitled to take an active part in the decisions or choices which affect his/her health. The individual is also expected and given an opportunity to provide input into the level, extent and development of health care services in his/her community.

5. "Accountability. Within the context of a health care system that is built on the principles of universality and accessibility, providers and consumers have a mutual obligation to use resources appropriately and responsibly.

6. "Cost-effectiveness. The provision of health care services is concerned with the optimal balance among cost, appropriateness and quality of care and efficient utilization of services.

7. "Commitment to the Future. Investment decisions are required in a number of new areas of innovation to ensure the continuing excellence of the system and its ability to meet future challenges. Health promotion, reduction of environmental health hazards, health research, education and innovation in the organization and financing of health care are key areas of commitment to the future. This process may involve reallocation of existing resources as well as new resources, both within and beyond the formal health care system."

IIb. The Premier's Council on Health Strategy

The Health Goals Committee of the Premier's Council on Health Strategy identified five broad goals* (17).

1. "Shift the emphasis to health promotion and disease prevention.

2. "Foster strong and supportive families and communities.

3. "Ensure a safe, high quality physical environment.

4. "Increase the number of years of good health for the citizens of Ontario by reducing illness, disability and premature death.

5. "Provide accessible, affordable, appropriate health services for all."

IIc. Principles for reform of long-term care (from "Strategies for Change")

The Province articulated seven principles to guide the reform of the long-term care system in "Strategies for Change" (1).

1. Individualization

   Services must be responsive to widely varying individual requirements in order to help people in an appropriate and flexible manner. Inherent in this principle is the belief that the dignity and uniqueness of each individual must be recognized and respected.

2. Independence and Choice

   Independence involves the individual's freedom to make lifestyle decisions in the course of daily living and reflects the right to make choices and take risks. Services should be designed, and operate, in ways that maximize the independence and choice of consumers.

3. Community Living

   The service system should strive to provide services and options that will assist people to live in their own homes and communities whenever possible.

4. Service Accessibility

The service system should provide a clearly identifiable point of access to services. Access should be simplified and integrated in order to be responsive to individual needs.

5. Support for Informal Caregivers

This principle recognizes the important role that family members, friends, neighbours, and volunteers often perform in providing assistance to many individuals. Services that complement and sustain informal caregiving must be recognized as an integral part of the service system.

6. Local Planning and Management

The service system will be planned and managed locally to develop the most suitable services for community needs. This service planning and management will occur within the framework of provincial standards and policy directions.

7. Affordability

The service system must be affordable within the limits of provincial fiscal policy, and available resources must be used effectively to meet needs. The costs of services should be shared among levels of government and consumers.

IId. The Board of Health's Programmatic Components for Reform of the Health Care System (Report of Dr. Michael Rachlis to the Board of Health, December/89)

A. Vertical Integration of Services.

This phrase refers to the financial linkage of different levels of care within health and social services. Presently, institutions and community services have separate budgets. These budgets have been established over time without relationship to the real needs of patients/clients. Someone might be assessed as having a need for a particular service (e.g., 24 hour homemaking for a short-term period) but, with present budgetary arrangements, it may not be possible to provide that service outside of an institution. If institutional services and community services have their budgets linked then resources may more easily flow to patients/clients based on need. This principle is particularly important because new technological advances (e.g., home respirator and intravenous therapies) and increasing numbers of consumers choosing care at home is driving up the demand for community services. However, the historical allocation of the lion's share of resources to institutions has limited the development of community services.

The vertical integration of funding may be accomplished in various ways. One method would be to allocate the entire budget for long-term care to a local health authority or municipal government. Another would be to allow for private non-profit corporations to be established to provide a spectrum of services to clients to eligible clients. (18)

Both Healthy Toronto 2000 and the Report of the Premier's Council Committee on the Health Care System suggest the possibility of some type of 'local authority' which might be responsible for the funding and management of health care and, to a more limited extent, social services.

B. A reallocation of funds to disease prevention, health promotion, and community services.

C. Democratization of the resource allocation process and the management of services.

Presently, the province negotiates a budget with each separate institution and community services are individually funded by a variety of public and private sources. There is little opportunity for consumers and the public at the local level to make decisions about the allocation of resources to different types of services (e.g., institutional vs. community services).

D. Giving individual patients and their families more informed choices about their own treatment programs.

E. Better evaluation of the effectiveness and efficiency of existing and proposed health services.

There is typically little evaluation of services and new services are not necessarily introduced as evidence becomes available. For example, as cited above, there has been evidence known for a while that geriatric assessment and regular nurse visitation can improve outcomes for certain frail elderly. And yet these services have not become in any way routine. We have known for some time that prescription drugs are dangerously overprescribed for many seniors and we have not seen appropriate responses.

III. The Essential Functions of a Long-term Care System

In developing models for the administration and delivery of long-term care, it is important to consider the functions and services provided in long-term care. This section describes the key components of long-term care.

IIIa. Intake

When people contact the system they require information and they should be initially screened for eligiblity and suitability.

IIIb. Assessment

The assessment process serves several functions. First, it provides information on diagnosis of illness and functional impairment. Second, it provides information on prognosis. Third, it provides information which is necessary for developing a plan of care. Fourth, it can be used to estimate the need for service and resources.

IIIc. Case Management

This term implies the active management of a person's care to ensure, as much as possible, the most effective and efficient use of resources to enhance that person's health and function. Strategies for Change suggests case management could be considered as synonymous with service coordination which is defined as, "A process that assists people in problem-solving activities such as identifying needs, exploring solutions, and mobilizing both formal and informal support services to achieve and maintain the highest possible level of independence."

Case management can involve assessment, care planning, advice on service selection, purchase of service, and reassessment. An organization providing case management could also provide service, although this is evidently precluded in Strategies for Change because of concerns about conflict of interest (see section IIIg).

IIId. Service Provision

The services required in long-term care may be provided by informal caregivers, single-service agencies, multi-service community agencies, institutions, and multi-level, multi-service agencies. The services may include hotel services (food, laundry, housecleaning, etc.), 'aging-in-place' services (handyperson, yard work, etc.), socialization, health promotion, assistance with activities of daily living, specialized services (medical, rehabilitation, special technology), and institutional services.

IIIe. Advocacy

Over the past two decades there has been the realization that vulnerable persons (such as the disabled and the frail elderly) may require the assistance of others to advocate for them in the acquisition of services. The Ontario government established an advocacy system for psychiatric patients in the early 1980s and the O'Sullivan Review of Advocacy released in 1987 recommended a comprehensive advocacy system for all vulnerable persons in the Province.

IIIf. Standards and Quality Assurance

Professor Jonathan Lomas of McMaster University has defined quality assurance as:

> "The measurement of health care activity, and the outcomes of that activity, in order to identify whether the expected objectives of the activity are being achieved and, when this is not the case, to respond with effective action to reduce the deviations from objectives." (19)

Dr. Geoffrey Anderson of the University of British Columbia has outlined a model for quality assurance (20). Figure 1 shows a modified version of this model.

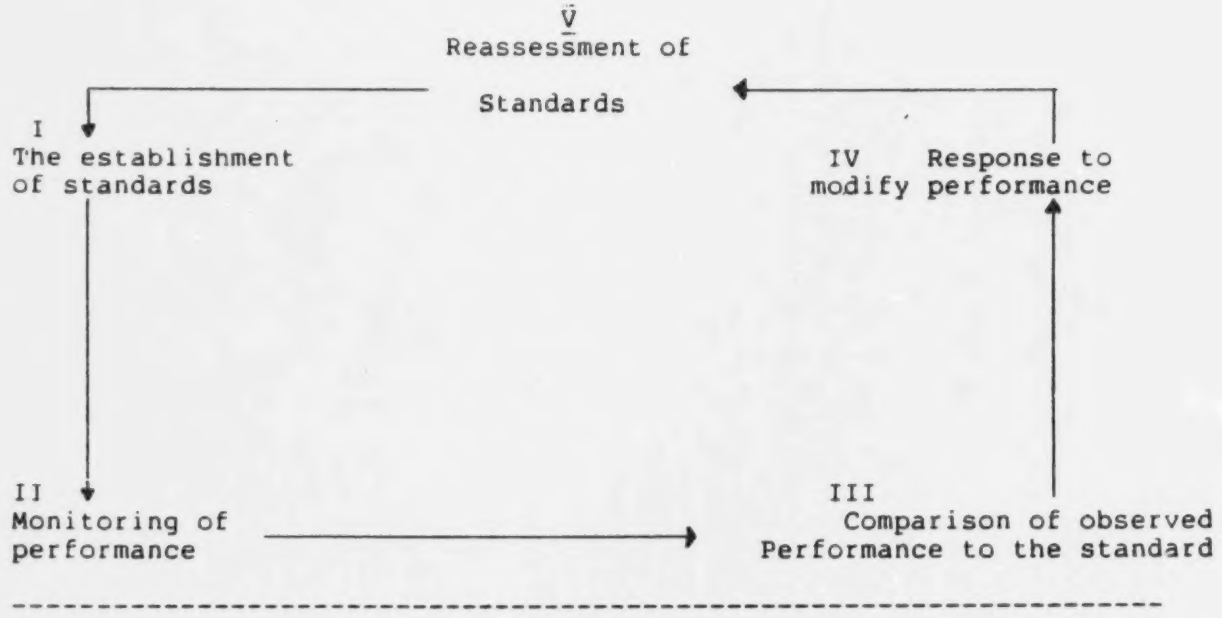
The first component in the model is the establishment of standards for procedures and services. This process should (ideally) use the best possible scientific evidence on effectiveness. The standards should be written and sufficiently explicit that their attainment may be easily and clearly determined. As much as possible, the standards should pertain to patient outcomes, not just structure or process.

The second component in the model is the monitoring of performance. The quality assurance process should collect data which will allow for determination of standard attainment.

Because it is desirable for the standard to relate to actual patient outcomes, the monitoring of performance should include information on health outcomes. However, the data collection process should not be so arduous that it is never completed.

The third component of the quality assurance process is the comparison of the provider's performance to the established standard. As well as assessing the provider's performance according to each standard, there should also be an overall evaluation of the provider's performance. For example, there might be an assessment conducted on a dozen individual performance standards related to attendant or nursing home care as well as an overall assessment of the provider's performance in this area with an eye to whether the caregiver should continue to provide the service. The difference between these two assessment activities is analagous to that between grading one subject and deciding whether a student has passed a school year. The fourth component is the response of the organization to modify performance which is below standard. Eisenberg has outlined six mechanisms to improve health care practice (21).

Figure 1. Model of Quality Assurance in Health Care



They include:

1. Education
2. Feedback
3. Participation
4. Administrative rules
5. Financial incentives
6. Financial penalties

Eisenberg documents that education and feedback alone are usually ineffective (21). In general, the other four strategies are more effective than education and feedback alone. Also, combinations of strategies are usually more effective than any one strategy alone.

Dr. Donald Berwick, the Vice-President for Quality Assurance for the Harvard Community Health Plan (a Boston-based health maintenance organization with over 800,000 members) has suggested that traditional North American industrial quality assurance programs rely too much on 'sticks' and not enough on 'carrots' (22, 23). He has suggested that health care organizations focus on creating environments which enhance their employees' productivity. He claims that an organization which is designed to continually improve the quality of its 'products' will produce higher quality goods and services than an organization which simply weeds out the 'bad apples'.

It is clear that development of standards for long-term care would have a direct impact on the services that would be deemed necessary for clients at different levels of need. Standards for long-term care would determine the resources needed for the system. Therefore, standards should be developed as soon as possible and must be in place before programs can be established and budgets allocated.

IIIg. Conflict of Interest

As mentioned above in section IIIc, Strategies for Change claims that it would be a conflict of interest for a service provider agency to become the Service Access Organization (SAO) which within the Province's model would be responsible for case management. The conflict of interest would exist, presumably because the provider would have an incentive to purchase services from itself and increase (inappropriately) the level of servicing. While this situation would entail a potential conflict of interest, it is interesting to note that other potential conflicts of interest exist in the health care system without apparent concern (24). Further, the organization of LTC services entails many other potential conflicts of interest and there are instances where organizing the system to maximize efficiency might be create potential conflicts of interest.

Kane and Kane identify that combining service provision with case management can lead to conflict of interest (25). They also indicate that a case management agency would have a potential conflict if it also provided advocacy services. However, Strategies for Change suggests that an advocacy function will be considered for the Service Access Organization. In general, Strategies for Change has not taken a broad view of the potential conflicts of interest which might exist within a LTC system. It has also not considered policies to check these conflicts or how controlling conflict of interest might adversely affect efficiency. For example, it would be more efficient for the service provider to be responsible for at least reassessment (if not the initial assessment). Also, if the service provider is responsible for case management and the delivery of all services then coordination and efficiency are facilitated. It is easier for workers in the same agency to communicate with each other to coordinate their care (26) and one agency reduces overhead costs (27).

It might be useful to explicitly identify the self-interests of the different organizations and individuals involved in the LTC system. It is understood in this analysis that these organizations and individuals have many other interests than their simple, raw self interest (professional, concern for others, concern for the general welfare, etc.)

The client has an interest in receiving as many services, at the lowest cost, in as convenient a fashion as possible. Further, the client would like to receive services which are tailored especially for his/her needs. The client usually has an interest in receiving as many services as are necessary to remain at home, even if the costs for care would be lower in a different setting (e.g., apartment building, nursing home).

A service agency paid a global budget has an interest in receiving as much revenue as possible for the fewest services possible. An agency paid on a fee-for-service basis has an interest in providing as many services as possible at the highest price for an individual service.

The individual service provider has an interest in providing as little service as possible for the most income.

The funding organization has an interest in paying as little as possible for services.

Politicians with political responsibility for the system have an interest in paying as little as possible for the most services with the minimum of political fallout.

The overall community has an interest in maximizing health and functional status with the use of the fewest resources possible.

Having explicitly identified the raw self interest for the different individuals and organizations one might proceed to clarify the checks and balances which might control conflict of interest without sacrificing efficiency or coordination.

The clearest potential conflict of interest is when one joins the assessment and case management functions. However, with clear provincial standards for assessment, a quality assurance mechanism to monitor the accuracy of assessments, and a clear, swift, accessible appeals process, the potential conflict of interest might not materialize. In a similar fashion, one could prevent the potential conflict of interest associated with the linkage of the case management and service provision functions.

The key mechanisms to prevent self interest from acting contrary to the overall community interest are clear standards for assessment and care (developed by funders, providers, and consumers), a thorough quality assurance process (administered by funders, providers, and consumers), an accessible, swift appeals process, clear lines of political accountability, and an advocacy system.

IV.

A Model for Long-term Care Based on the Principles for Reform This section identifies models for long-term care which are congruent with the principles for LTC reform from Strategies for Change.

IVa. Intake

The intake process should be accessible to persons with various disabilities and languages. If persons are clearly not suitable for LTC services then they should be referred to the appropriate agency or service provider to deal with their problems. The intake process could be performed by the agency responsible for assessment or an existing one (e.g., public health unit or information agency).

IVb. Assessment

The assessment should be based on Provincial standards and there should be quality control mechanisms in place to ensure that the assessments are performed in the same fashion with the same results throughout the province. The assessment process should be multidisciplinary and involve physical, functional, mental, social, and economic domains. This is in keeping with the literature on geriatric assessment which indicates such an assessment would maximize independence and function. The assessment should result in the determination of a level of care which is based on the best scientific evidence of what works and how to get the best bang for the buck.

The assessment could be performed by a variety of different organizations. The Province could take direct responsibility for this function through a series of field offices. However, to prevent a conflict of interest (there will be an incentive to assess people below their level of true need) the lines of accountability should be clear and direct. The staff should directly report to the Assistant Deputy Minister of Community Services (who reports to both the Ministers of Health and Community and Social Services). There must also be a expeditious appeals process and an arms-length advocacy system.

Alternatively, the assessment could be performed by the agency responsible for case management (see below). In this case, to avoid a conflict of interest, the agency should be directly accountable to some political authority (e.g., public health unit, community services branch of municipal government) and there must be an expeditious appeals process and an arms-length advocacy system.

Finally the assessment could be performed by an agency solely dedicated to that purpose. In this case there is no conflict of interest for this agency but there would still need to be an appeals process and an arms length advocacy system.

IVc. Case Management and Service Provision

It is more efficient to have these functions performed by the same agency, as mentioned above. This would meet the principle of affordability. It would be possible to prevent a conflict of interest if there were clear provincial standards for assessment, a quality assurance mechanism to monitor the accuracy of assessments, and a clear, swift, accessible appeals process.

Affordability, individualization, independence, community living, and support for informal caregivers would be maximized if the budgets for institutional and community services were integrated. This 'vertical integration' (see section IId) would allow for an increase of the community services budget with a reallocation of resources from the institutional sector. However, with so much authority vested in this one organization it would be necessary for it to be readily accountable to some responsible political body. This could be municipal government or a district health council if it were vested with similar powers to school boards. This arrangement would meet the principle of local planning and management.

The services themselves should have an emphasis on health promotion, whether they are delivered in the community or institutions. This would maximize the independence of clients. There should be a range of services with the opportunity for clients and their families to choose, as much as possible, those services that would maximize their quality of life according to their own preferences.

To further increase consumer choice, one could consider a system which transferred the dollar value of services required at each level of assessed need directly to the client. In other words, if it were estimated that services would cost $1200 per month for a particular level of assessment, this money could be given directly to the client. The transfer could be made with cash or a voucher. In any event, there would need to be a full audit to ensure appropriate use. The Province of Manitoba has recently initiated a pilot project with 30 young disabled persons where they are given a cash transfer and then they arrange and pay for all their services. While this system clearly maximizes individualization and personal choice, there would need to be provisions for emergency assessments and/or services if clients acutely deteriorated.

IVd. Advocacy

An arms-length advocacy system would assist in fulfilling the principles of individualization, choice, and community living. However, assuming that hundreds of thousands of persons would meet the criteria of 'vulnerability', this system would add tens of millions of dollars to expenditures on long-term care. It would be sensible to make advocacy a priority for those persons living within institutions (the most vulnerable) and then add it for those in the community over time. In any event, there would need to be a clear appeals mechanism for assessments and service provision. The advocacy and the appeals system could not operate without clear and reliable Provincial standards.

IVe. Standards and Quality Assurance

Strategy for Change refers to the establishment of Provincial standards under the principle of local planning and management. However, there is very little mention of standards in the rest of the document except for the mention of service standards within institutions. There is no mention of quality assurance. However, as mentioned above in this section, clear standards for assessment and service delivery are prerequisites for the smooth working of the LTC system.

In an ideal system government, providers, and consumers would develop clear standards for assessments and service provision. This would not necessarily preclude an individual client choosing services according to their own preferences. While others (local government, consumers, providers) would be involved in the development process, it is crucial that the Province take overall responsibility for the establishment of minimum Provincial-wide standards and quality assurance. Provincial standards are necessary to ensure that persons are treated equitably across the province. These standards would also be necessary to ensure affordability and service accessibility.

V. Different Models of Long-term Care Delivery

The functions described in Section III could be provided by one organization/agency or they could each be provided by separate organizations or there could be various combinations. These different combinations of functions outline different models for the administration and delivery of long-term care.

This section describes four models of delivery of long-term care services and then rates them according to the principles for reform described in Section II. The four models were selected to cover the range of policy options which might be considered by the City of Toronto. However, considerations of space do not allow the inclusion of all the details of each of the models and these details might well change the ratings somewhat. The ratings should be seen as broad guidelines for evaluating proposed models for service delivery. Table 1 shows the ratings for the four models.

Policy option #1 - The model most likely from Strategies for Change

Although Strategies for Change could lead to a variety of models there are certain features that are evidently already decided. Figure 2 from the document shows the proposed new system graphically. The model that seems most likely would be composed as follows:

Assessment:

The assessment would be conducted by the proposed service access agency (SAO) or would be conducted under its direction.

Case Management:

The SAO would develop a plan of care with the individual and his/her family and informal caregivers. Then the SAO would purchase community services from the appropriate agency. The SAO would be responsible for developing a facility placement committee which would review applications from individuals who requested institutional placement. The facility placement committee would have sole responsibility for the authorization of extended care certificates.

Advocacy:

Strategies for Change says that an advocacy function and a means for appeal will be considered for the SAO.

Reformed Long-Term Care System

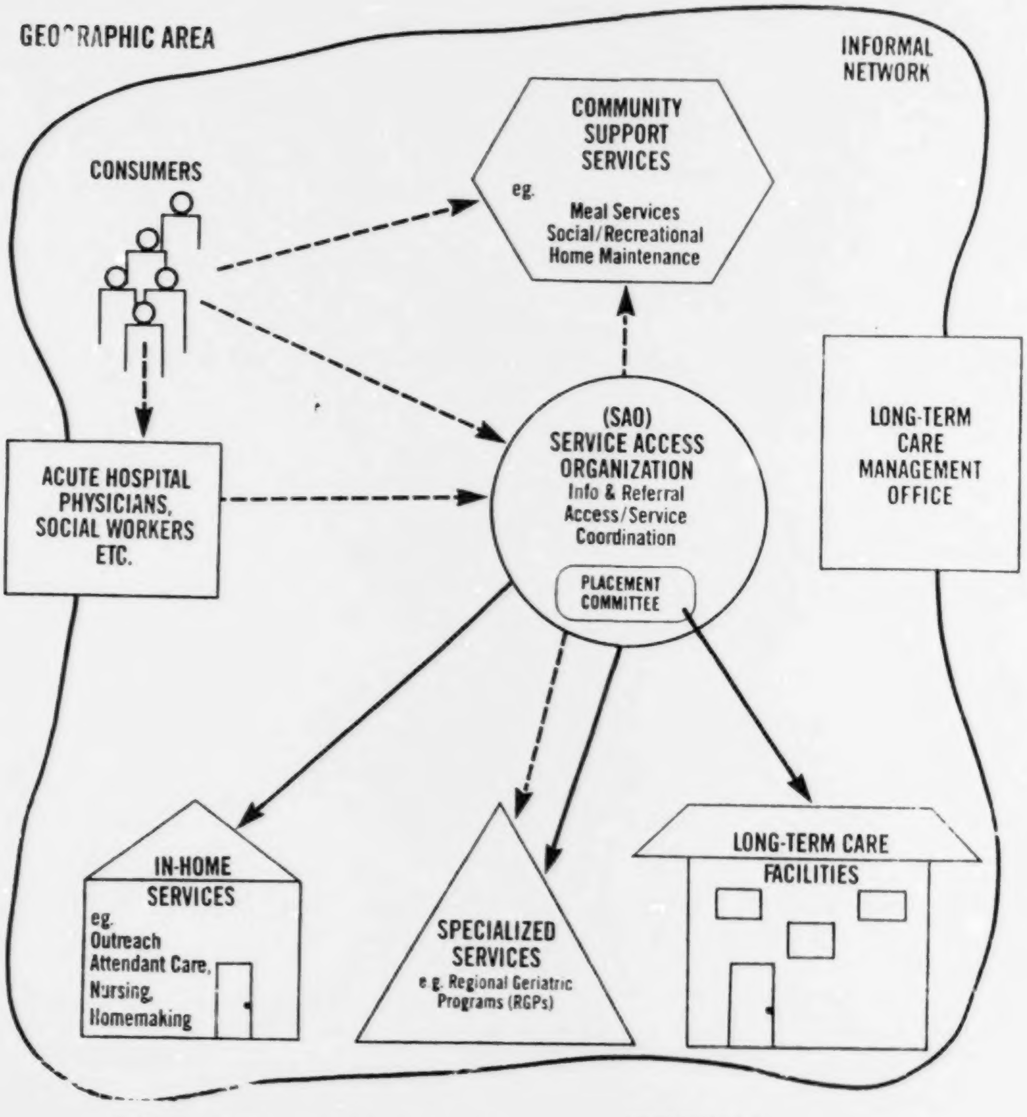

GEOGRAPHIC AREA
INFORMAL NETWORK
CONSUMERS
COMMUNITY SUPPORT SERVICES
eg.
Meal Services
Social/Recreational
Home Maintenance
ACUTE HOSPITAL PHYSICIANS, SOCIAL WORKERS ETC.
(SAO)
SERVICE ACCESS ORGANIZATION
Info & Referral
Access/Service Coordination
PLACEMENT COMMITTEE
LONG-TERM CARE MANAGEMENT OFFICE
IN-HOME SERVICES
eg.
Outreach
Attendant Care,
Nursing,
Homemaking
SPECIALIZED SERVICES
e.g. Regional Geriatric Programs (RGPs)
LONG-TERM CARE FACILITIES

Figure 2. From Strategies for Change

ACCESS THROUGH SAO ———
DIRECT ACCESS/REFERRAL - - - - - -

Service Provision:

Community services will be provided by a variety of agencies. As mentioned above, the services will be purchased by the SAO.

Standards and Quality Assurance:

There is very little discussion of standards and quality assurance in Strategy for Change. There is reference to the development of standards for institutions but there is very little detail and no discussion of quality assurance.

Critique: Table 1 shows the ratings of the models. This model rates very poorly on the principles, values, and goals grid. Without clear standards for care or a developed quality assurance program, the quality of care would be uncertain, and there would be no method for ensuring the equitable provision of care from one client to another or one part of the province to another. The model has many inherent inefficiencies. Because the SAO would purchase services from a myriad of community agencies there would be increased costs for administration, the more agencies involved, the greater the inefficiencies.

There is a lack of accountability in the model as the SAO would report to the local manager from the Provincial Government who would, in turn, report to the Ministries of Health and Community and Social Services. Therefore, the SAO is remote from the Provincial government and is not accountable to the local community. There is no discussion of health promotion although presumably these programs could be included in the model.

It is not clear from Strategies for Change how the community services network would be established. It is admitted that the present community services are uncoordinated and have gaps. Depending how the services are developed there might or might not be real choices for individuals. If there is a limited range of services with limited providers and the individuals are not allowed to purchase their own services with some voucher system, then the model would fare poorly on informed choice and individualization.

The vertical integration of services are precluded in this model. There would be a fixed community services budget with no guarantee of a reallocation of resources. There is no local democratic decision-making for resource allocation and there is no reference to evaluation.

Policy option #2. A model similar to one used in British Columbia and parts of Alberta

In this model, the home care program (administered by the Department of Public Health), provides assessment, case management, coordination, and delivers most of the professional services. A study was conducted which compared this service in the North-side of Calgary with a model similar to the #1 above in the South-side of Calgary (28). The costs per nursing visit were 21 percent higher on the South-side because of the increased administrative expenses. Further, the costs per case were increased by 48 percent because of an increased number of nursing visits per case. The authors of the study hypothesized that this was the result of the fee-for-service incentives for the program on the South-side which encouraged more visits, less teaching of self-care, and the continuation of patients on the case load.

Assessment:

The assessment would be conducted by the same agency providing case management and, at least some of the professional services (in particular, nursing).

Case Management:

The same agency providing the assessment would also provide case management. Requests for institutional care could be processed by a committee of the Public Health Department or a separate body.

Advocacy:

There is no specific advocacy function in this model. It would have to be added.

Service Provision:

Some professional services (in particular, nursing) would be provided by the assessment/case management organization. Other community services would be purchased from a variety of agencies. A separate process would be used to establish eligibility for institutional care. Institutions would remain autonomous.

Standards and Quality Assurance:

These would be synchronized with other standards and quality assurance activities undertaken by the Department.

Critique:

Table 1 shows the ratings of the models. This model generally scores better than #1 although there are many components which would need to be more fully developed. This model is more efficient because of the lowered administrative costs. However, it is not as efficient as a fully vertically integrated model as discussed in policy option #3. It is more accountable than #1 because it is administered by a Public Health Department which is responsible to a Board of Health or committee of local government. In a similar fashion, this model scores better than #1 on local planning and management and democratization of resource allocation. The use of public health nurses may increase the likelihood of health promotion being included.

However, it is not clear how much this model would allow for informed choice and individualization of care plans. There may be more chance of effective standards and quality assurance mechanisms being implemented because of the association with a Department of Public Health.

Policy option #3. A model with full vertical integration of all service delivery and a focus on health promotion

In this model the assessment for eligibility is conducted by a government agency and the services are provided and managed by one organization. This organization could be governed by a community board like the On Lok Seniors Health Service in San Francisco or by a local health authority. The conceptual framework for this model is drawn from the On Lok Service which was described in a previous report to the Board of Health in February, 1990. A description of the service is included as an appendix to this report.

Assessment:

The assessment would be conducted by a government organization. People are determined to be eligible for service according to predetermined criteria. They are funded for care according to their level of assessed need.

Case Management:

The same agency providing the services would also provide case management. Requests for institutional care could be processed by a separate governmental committee. On the other hand, the service provider would also have control over or access to at least some institutional beds.

Advocacy:

There is no specific advocacy function in this model. It would have to be added.

Service Provision:

All services are provided by one agency — the same one responsible for case management. There is a focus on health promotion, in particular, nutrition and socialization. Services are provided in people's homes but the majority are delivered through day facilities. This encourages socialization. The On Lok Service provides medical care, and pays for acute hospital care and prescription drugs. This allows On Lok to reallocate funds from these areas to day programming and health promotion. A modified version of On Lok could just integrate the funding for long-term care services.

Standards and Quality Assurance:

These would have to be developed.

Critique:

Table 1 shows the ratings of the models. This model scores better than #1 or #2 on most areas. Because of the vertical integration of service delivery, it is more efficient than either of the previous models. The use of a congregate day facility would also likely decrease costs. It is more comprehensive in its services. The accountability of the model depends upon the sponsoring body for the service provider and its relationship to government. If it is directly operated by local government or if there are clear lines of reporting to government with specific standards and quality assurance there will be reasonable accountability. Because there are financial incentives to underservice clients there is a particular need for quality assurance and consumer involvement with this model. The latter might be accomplished through an advocate. There would also be the opportunity for democratization of resource allocation decisions.

This model fully incorporates health promotion and therefore, scores well on goal #1 from the Premier's Council. Individualization of care should be favoured in this model because there are no particular barriers to tailoring services to the specific client's needs. The organization has an incentive to enhance independence because then the particular client's care needs are reduced. In a similar fashion there is an incentive to provide support to informal caregivers. By definition, this model rates well as vertically integrating services.

Policy option #4. A model tranferring resources for care to individuals who then decide which services to purchase

In this model an assessment would be conducted by a government body and this assessment would determine the level of care and resources to be allocated. The individual would then be given the dollar value of the services estimated to be required or a voucher for services. He/she could then purchase these services from any agency or individual. The services might be provided by individual agencies or one vertically integrated organization as described in policy option #3. This model opens up a free market for services with the sum of individual choices in a community determining the eventual spectrum of services. There would be audits conducted to ensure the appropriate use of resources within established provincial standards.

Assessment:

The assessment would be conducted by a government organization. People are determined to be eligible for service according to predetermined criteria. They are funded for care according to their level of assessed need. The individual is given the monetary value of the services estimated to be required or a voucher for care.

Case Management:

The individual would be required to purchase case management services. Case management could be provided by a service delivery organization or a specific organization dedicated to case management. Individuals desiring institutional care could purchase that with their vouchers.

Advocacy:

There is no specific advocacy function in this model. It would have to be added.

Service Provision:

The services provided are determined by the sum of the individual choices. Because vertically integrated service delivery organizations would be more efficient (lower administrative costs) they would be favoured. However, innovative single service agencies could establish a niche. A modified version of On Lok might well develop in such an environment.

Standards and Quality Assurance:

These would have to be developed. Because the consumer is deciding directly on service providers, the model might need some sort of licensure or certification of service providers to assure basic quality. At the least, there would need to be a thorough quality assurance process.

Critique:

Table 1 shows the ratings of the models. This model scores better than #1 or #2 on most areas. In particular, it rates highly on allowing informed choice and individualization of care. Efficiency is better than #1 or #2 because there are incentives for providers offer a good price in the marketplace. However, there would likely be problems with development of services in remote regions. There would need to be special arrangements for these areas of the Province.

This model would also be more comprehensive than the others and would likely enhance community living versus institutional care. Because individual clients and caregivers would develop the treatment plan, it would maximally support caregivers. This model would reallocate resources from institutions to community care.

There are some potential difficulties for an unmodified form of this model. If a client deteriorated suddenly, or if his main caregiver took ill, there would need to be some method of immediately increasing resources. This could be accomplished by providing emergency assessments, offering authority to service providers to temporarily supply more resources with compensation, or by having local communities provide certain 'emergency' services. If someone were medically or functionally unstable or had an acute deteriorating condition (terminal cancer), then the provision of specific services (e.g., palliative care) might be required. This model would function best for someone with a fixed disability which could be expected to remain stable for several years.

Table 1. Consistency of four different policy options for long-term care with principles of health care reform.—' indicates the policy is quite inconsistent, -' somewhat inconsistent, + +' quite consistent, +' somewhat consistent, ? means it was difficult to assess consistency. See text for definitions.

	Policy Options			
	1	2	3	4
Values (from Evans Panel)				
1. Equity	?	?	?	?
2. Quality	?	?	?	?
3. Comprehensiveness	-	?	+	+ +
4. Informed Choice	-	?	+	+ +
5. Accountability	-	+	+	+
6. Cost-effectiveness	—	+	+ +	+
7. Commitment to the future	?	?	+	?
Goals (from Premier's Council on Health)				
1. Shift the emphasis to health promotion and disease prevention.	?	+	+ +	+
2. Foster strong and supportive families and communities.	?	?	+	+ +
3. Ensure a safe, high quality physical environment.		N/A		
4. Increase the number of years of good health for the citizens of Ontario by reducing illness, disability, & premature death.	?	?	+	?
5. Provide accessible, affordable, appropriate health services for all.	-	+	+ +	+
Principles for reform of long-term care (from Strategies for Change)				
1. Individualization	-	?	+	+ +
2. Independence and choice	-	?	?	+ +
3. Community living	-	?	+	+ +
4. Service accessibility	+	+	+	+
5. Support for informal caregivers	?	?	+	+ +
6. Local planning and management	-	+	+	+
7. Affordability	-	+	+ +	+

Programmatic components of reformed health care system (from the Board of Health)				
1. Vertical integration of services		+	++	+
2. Reallocation to disease prevention, health promotion, & community services	-	?	++	+
3. Democratization of allocation and management	-	+	+	++
4. Informed choices to patients and families	?	?	+	++
5. Evaluation of new and existing services	?	?	?	?

Appendix 1

On Lok Senior's Health Services

On Lok Senior's Health Services opened its non-profit operation for the "frail" elderly in 1973 with its first day health centre located in a renovated Broadway nightclub. Today, from three such centres, On Lok serves 300 high-risk seniors, whose average age is 81, and who have between five and six serious medical diagnoses each. Clients of this program are very frail indeed. Three-quarters of On Lok's participants are incontinent and three-quarters have difficulty using their limbs. In addition, many are at special risk because of poverty and isolation. Two-thirds of its particpants live alone and 41 percent are poor enough to qualify for SSI (Supplemental Security Income). Located in San Francisco's Chinatown, many of On Lok's enrollees are Chinese (75 percent), although Filipinos, Italians, other Caucasians and Blacks also use its services. To participate in this program, applicants must be over 55, and be medically assessed by a state representative as needing nursing home care. But instead of going on to become institutionalized, most of On Lok's enrollees remain in their own familiar surroundings and receive whatever supports they require to remain there.

Those participants who qualify for both Medicare and Medicaid pay nothing. (In the United States, Medicare pays the institutional and medical service costs for the elderly; Medicaid provides similar coverage for the poor). The remainder pay on a sliding scale according to income. On Lok's financing is very creative. As mentioned earlier, before joining the program, each prospective participant must first qualify for nursing home care, as determined through an independent assessment done by a state representative. The government funds On Lok on capitation, a fixed amount per month for each participant. The capitation level is based on 95 percent of what government would have had to spend on nursing home care for these participants through Medicare and Medicaid programs. As of 1987, this worked out to a capitation level of about $1,900 U.S. per month per participant. This is not much different from what an Ontario nursing home receives for semi-private care. On Lok uses this money to help keep their participants out of institutions and in the mainstream of life.

The capitation payment allows On Lok great flexibility in program design. They don't have to specifically use their revenue for institutional or physicians' services and, by and large, they don't. Table A1 shows a comparison of the proportional spending by the Ontario Ministry of Health and On Lok. It is not possible to completely separate out expenditures for seniors from overall expenditures for the Ministry of Health. However, the differences in the table are too great to be changed much even by only comparing those over 65. On Lok has turned the traditional funding 'pyramid' upside down. It only uses 14 percent of its budget on institutional care and nearly half the budget on day programming and home care services.

Table A1. A comparison of proportional spending in 1985-86 by the Ontario Ministry of Health and the On Lok long-term care program.

	MOH	On Lok
Institutional care (acute and chronic)	64%	14%
Outpatient medical care	17%	14%

Day health services and home care	1.7%	46%
Administration	1%	9%
Research and development	0.4%	7%
Other	15%	10%

To do this, the program hires or contracts with staff to provide all sorts of services with a special emphasis on those most usually associated with the problems of aging. The program has two salaried, full-time doctors as well as two half-time physicians for night call. On Lok participants have access to a wide range of medical and other health care specialists whose training is pertinent to their particular needs - geriatricians and nurses with a gerontology background, rheumatologists, neurologists, psychiatrists, audiologists, podiatrists, physiotherapists, speech therapists, etc. But On Lok also has social service specialists on staff, who focus on reducing the isolation common to so many elderly people by involving participants in planned recreational activities. It is this component of the program, which increases possibilities for social contacts and helps to promote an enjoyment of life.

For fifteen years On Lok has operated in the black. Overall, the cost to government has gone down. It costs U.S. Medicare 11 percent less than it would have to pay for similar beneficiaries in the more traditional system, while the Medicaid program saves at least five percent.

The Cantonese words "On Lok Geui" mean abode of peace and happiness, and were chosen to reflect the philosophy of a program committed to the concept of "managed care" with a difference.

On Lok's record of success speaks for itself. Their elderly, mainly poor, extremely frail population have an overall institutional rate of only six percent, with five percent in a nursing home and only one percent in an acute care hospital at any given time. On Lok has managed to reduce hospitalizations due to flareups from chronic conditions to nearly zero, a truly remarkable achievement and strong evidence that careful monitoring and appropriate servicing can dramatically reduce institutionalization even among the very infirm. When you compare On Lok's six percent institutionalization rate for such frail elderly people to Canada's own dismal record, where as many as ten percent of all people over 65 are in institutions, our scope for improvement is very large indeed.

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24. For example, physicians routinely recommend services to their patients which they then supply. For example, a cardiologist might refer a patient for a stress electrocardiogram which he would perform and for which he would bill. Then the cardiologist might recommend angioplasty which he would again perform and for which he would receive payment. Surgeons recommend surgery without requiring approval from a third party. Dentists recommend courses of therapy which they perform. Many other examples might be cited.

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26. This arrangement also prevents a situation where different agencies have different policies which are at cross purposes (e.g., defining the level of risk that is acceptable for a community client).

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The Board of Health also submits the paper from The Ontario Coalition of Non-Profit Organization Working With Seniors entitled "Managing the Transition - A Response to the Government of Ontario's Long Term Care Strategy":

Summary and Recommendations:

The Ontario Coalition of Non-Profit Organizations Working with Seniors represents virtually the entire not-for-profit, community-based system of care providers as well as a number of consumer groups.

Collectively we serve hundreds of thousands of seniors, mobilize tens of thousands of volunteers and employ thousands of professionals and front-line workers in the delivery of health and social services to the elderly and disabled.

This paper represents our collective response to the recent Report of the Task Force on Long Term Care, entitled "Strategies for Change: Comprehensive Reform of Ontario's Long Term Care Services".

We believe that this discussion paper is the most comprehensive strategic plan ever developed by the Government of Ontario on the issue of senior's services.

For the most part, the basic directions are clear. Indeed they are welcomed by consumers and providers of care for the elderly.

We agree with the general thrust of the government's strategy to expand and develop an effective community care and support service system.

We endorse the government's plan to decentralize the planning and funding functions to the community level.

And we support the concept of a single access agency as the entry point into the long term care system.

This paper presents our sector's initial reaction to "Strategies for Change" and makes a series of recommendations which we hereby submit to the Ministers responsible for long term care for their consideration.

In summary, we recommend:

1. That the Ministers establish a meaningful consultation process that will enable the provincial associations in long term care to review "Strategies for Change" and the directions it establishes. We suggest that at least $12 million be set aside for provincial organizations and local agencies to hire planning staff; acquire management information systems; develop pilot projects; and hold conferences and seminars that will enable the sector to work together with government on creating a consensus on the component parts of the key initiatives proposed in the government's strategy document.

2. That the Ministers responsible for long term care reform meet with the Coalition to discuss funding projections and assumptions that arise out of the proposed restructuring of the system.

3. That the government fund agencies responsible for in-home care and support programs using global budgets rather than fee-for-service arrangements, in order to maximize flexibility and overcome the serious disadvantages encountered under present funding arrangements.

4. That the Ministers appoint an Advisory Committee on Legislation governing long term care services - with representation from consumers, the Ontario Hospital Association, the Council of Chronic Care Hospitals of Ontario, the Ontario Public Health Association, the Ontario Association of Non-Profit Homes and Services to Seniors, the Coalition of Non-Profit Organizations working with Seniors, and the Community Health and Support Services Division.

5. That the Ministers consider ways to ensure an appropriate balance of "health" and "social service" perspectives as we move towards the implementation of the long term care reform program. We also suggest that consideration be given to the eventual establishment of a new Ministry of Community Health and Support Services which would forge a balanced orientation between the two perspectives.

6. That the Ministers establish policies that clarify the respective roles of the not-for-profit agencies and the commercial companies involved in long term care.

7. That the government fund a study to address human resource planning - including the numbers and mix of professionals and paraprofessionals necessary to meet provincial standards and core program requirements of the long term care program.

8. That the government develop specific funding mechanisms to address the existing human resource shortages by improving training, recruitment and retention of personnel, consistent with current and projected human resources required by the long term care reform program.

9. That the government establish a "Multi-Service Sponsor Transition Fund" that would enable agencies to retain experts to advise them on strategies for diversification. While the macro analysis and general feasibility studies should be conducted by provincial organizations, a major component of this fund should be reserved for local agencies in co-ordination with local area managers.

10. That when the newly-created Advisory Committee on the Patient Classification System has completed its work, provincial organizations should be formally consulted to develop an agreed-upon funding formula for each level of care designated.

11. That the government work closely with the Ontario Association of Non-Profit Homes and Services for Seniors and the Ontario Nursing Home Association in designing a reformed system for financing the extended care system and that the primary consideration be the development of enhanced activation and rehabilitation programs for residents.

12. That the government work with consumers and representatives of the Long Term Care Residential Care Association in developing legislation that will provide standards for the future development of the Retirement and Rest Home sector.

13. That the Ministers commission an independent study to examine institutional bed needs in 1992-1998 that takes into account the progress of the community-based system in effecting reductions in bed requirements, the higher acuity levels among institutional residents, and the impact of demographic realities.

14. That the newly-established Advisory Committee on the Role of the Chronic Care Hospital be mandated to review the role of rehabilitation within the long term care system and to recommend provincial "standards" for institutional service and "core programs" that should be available in each community. This committee should also examine current and projected staffing requirements that will enable them to deliver a high quality of care to an increasingly chronic caseload. The Ontario Association of Non-Profit Homes and Services for Seniors and the Ontario Nursing Home Association should be asked to do the same study for the extended care system.

15. That the Ministers establish a Consultation Committee on the Integration of In-Home Services with the provincial associations of the VON, Ontario Visiting Homemakers Association, the Ontario Home Support Association, Meals-on-Wheels of Ontario, Older Adult Centres' Association of Ontario and the Coalition of Senior Citizen's Organizations to review the government's evolving strategy for the re-structuring of the sector. In particular, Ministers should listen care-

fully to our views on the role of the Registered Nurse and the importance of neighbourhood-based services to the elderly.

16. That the government develop a draft set of "Guidelines for Facility Placement Committees" and circulate them to provincial associations for comment and further suggestions.

17. That the government develop draft "Guidelines for Service Access Organizations" and circulate them to provincial associations for comment and input from the long term care sector.

18. That the government institute a policy whereby Service Access Organizations be administered by community boards with balanced representation from consumers, providers and municipal and provincial appointees.

19. That Service Access Organizations be selected in each community by a special Long Term Care Committee of the local District Health Council and that non-profit service providers be considered as eligible candidates.

20. That Long Term Care Committees of DHCs become the final authority on the recommended allocation of each community's long term care budget - based on the submission of the local manager, and after hearing appeals by local agencies.

21. That the government establish and fund an Advisory Committee on Quality Assurance to establish a process for ensuring quality of service delivery in the long term care system - consistent with the current emphasis on "continuous improvement", and complementing those programs currently operated by professional licensing bodies. This committee should also review the proposed financial accountability systems to ensure a minimum of paper burden and an appropriate balance between "quality and effectiveness" and "financial accountability".

22. That the government support the development of specific strategies to enhance team-building among providers of long term care in both the community and institutional settings by clarifying that the care team will be responsible for ongoing patient monitoring and assessment and is expected to make appropriate adjustments to the service plan in line with changes in patient status. We reject the idea of annual re-assessments by the Service Access Agency because it is unrealistic.

23. That the government mandate its various advisory committees to develop and draft suggested province-wide "standards" and "core programs" that will serve as the basic minimum programs and services that will be available in each community. Once the government has a draft of the proposed standards, they should be reviewed by provincial provider groups, consumer representatives and appropriate health care professional colleges and associations.

24. That the government implement the recommendations of the Report of the Interministerial Committee on Visiting Homemaker's Services to provide training for homemakers.

25. That the government set homemaker wages at $11.50 per hour as soon as possible in order for agencies to comply with the province's pay equity legislation and to respond to the Premier's Council's policy of equalizing wages between the institutional and community-based sector. This provincial base rate would become the minimum wage for homemakers and local rates would be negotiated from this base.

26. That the government establish a drug education program aimed at seniors and the professionals who work with them in the long term care sector.

27. That the Minister establish an Advisory Committee on Palliative Care with a mandate to develop a co-ordinated policy for the development of institutional and community-based palliative care. This committee should have representation from the existing palliative care organizations, the Ontario Hospital Association, the Council of Chronic Care Hospitals, the Coalition of Non-Profit Organizations Working with Seniors, the Registered Nurses' Association of Ontario and the Ontario Association on Non-Profit Homes and Services for Seniors.

28. That, in consultation with the Older Adult Centres' Association of Ontario, the government set up an Advisory Committee on the Role of Elderly Person's Centres in providing health promo-

tion/illness prevention programs and in-home support services and to discuss ways in which we can enrich seniors' recreation programming at the municipal level.

29. That the government set up an Advisory Committee on the Role of Meals on Wheels as a health promotion/illness prevention service and to review the costing of meals supplied by hospitals and homes for the aged as well as to examine other sources of supply.
30. That the government consider establishing independent local mechanisms to respond to and investigate consumer complaints within the institutional and community-based components of their long term care system.
31. That the Ministers commission an independent study of the impact of co-payment on accessibility to services. The authors should be asked to recommend approaches that will ensure fairness and equity. We suggest that the McMaster University's Centre for Health Economics and Policy Analysis be considered as an appropriate candidate for such a study.
32. That the government fund a study to develop a comprehensive strategy on volunteerism in long term care. Such a study would examine the opportunities for a province-wide recruitment campaign and recommend strategies for co-ordination, training and retention of volunteers.
33. That the federal and provincial governments examine the option of tax incentives to support family caregivers and that the province provide At-Home/Chez Nous with funds to prepare a professional brief to federal and provincial governments on suggested tax incentives and other forms of government support for families.
34. That the government develop provincial standards for Caregivers Relief Programs for emergency and pre-planned respite care that establish reasonable expectations of institutional and community-based services that should be available for family caregivers.
35. That the government clarify its commitment to continue providing in-home services to non-elderly and non-disabled persons. Access to home care and home support services by, for example, new mothers, or post-operative patients are important aspects of community service which have an impact on reducing the utilization of acute care.

We respectively submit these recommendations to the Ministers responsible for long term care reform and look forward to an early meeting at which we can begin the dialogue that will enable us to refine the long term care strategy and to begin the challenging task of implementation.

The Board of Health also submits the communication (October 9, 1990) from Mr. Reeve James L. Wales, President, The Association of Local Official Health Agencies (A.L.O.H.A.):

The Association of Local Official Health Agencies is pleased to submit the attached response to the Provincial Government's joint Ministry document entitled "Strategies for Change".

A.L.O.H.A. supports the vision of long term care reform for Ontario's seniors and the major role to be played by Boards of Health within their present mandate. We further support the expansion of this mandate to include provision of information, referral, access and service coordination for long term care facilities, in-home and specialized services.

We hope that this clarifies the potential role of Boards of Health in the reform process and that you find A.L.O.H.A.'s response useful.

A.L.O.H.A. Position on Long Term Care Reform:

Introduction:

The direction of the reform of Ontario's Long Term Care System as presented in the document "Strategies for Change: Comprehensive Reform of Ontario's Long Term Care Services" is positive and welcomed by the Association of Local Official Health Agencies and its Sections. The Report's principles and twelve strategies incorporates information from previous reviews and studies (Operational Review of Home Care Program, Homemaker Rate Review, Integrated Homemaker Program Review), to which A.L.O.H.A. has contributed.

A.L.O.H.A. endorses the rationalization of provincial funding for these various programs, the concept of flexible care being provided in in-home services, the concept of a Placement Review mechanism to ensure that residents are placed in appropriate facilities and in the appropriate order, the introduction of an appeal process, the funding of institutions according to level of care provided, the acknowledgement of the important role of informal care givers, and the establishment of the Service Access Organization (S.A.O) to provide information, assessment, assistance, and cohesion to the system.

Role of Boards of Health:

Boards of Health with their present mandate are logically suitable to have a major role in this reform. While the scope and nature of the role may vary between Health Units, their suitability and compatibility with the reforms in directions and strategies can be strongly supported:

1. Boards of Health, with the Medical Officer of Health as the C.E.O., have shown leadership in providing and supporting initiatives in the community that reinforce the broad concept of "health" as defined by the World Health Organization. The determinants of "health" are multiple and encompass social, economic and educational conditions. Health is seen as more than absence of disease, as in the traditional medical model.

   Health Units, through their disease prevention and health promotion mandate, have expertise in community development and recognize and support the importance of grass roots consumer input and control (creating enabling environments that empower individuals to gain control over their health and their environment).

2. Boards of Health also have expertise with home health treatment and case management.

   Twenty-nine of the 38 present Home Care programs (Acute/Chronic, School Health Support Services and Assistive Devices) are administered by Boards of Health. These programs may also include Integrated Homemaking and Placement Coordination Services.

   Health Units have a broad perspective concerning community-based disease prevention and health promotion programs, home health treatment programs and case management. They have shown an ability to link with numerous agencies and consumers, and to deliver programs in a financially responsible manner.

   Therefore Boards of Health are best positioned with their involvement in community-based health and social services issues and programs to be the S.A.O.

Discussion of Criteria of S.A.O.:

The criteria that determine the S.A.O., as outlined in the report, would include Boards of Health.

It is recognized that there are different types of conflict of interest. These may apply differently to Boards of Health depending on their structure (municipal, regional, county/district). Boards of Health mainly administer the present Home Care Programs and do not provide direct services, but rather contract out to services already available in the community. Some Boards, however, have had to develop and provide direct services due to lack of such services in their community.

Conflict of interest is part of the overall question of accountability. The Program must be accountable to the public and funders (Provincial Government) for its actions.

In discussing the issue of conflict of interest, it is important to recognize different levels and types of conflict of interest: the primary reference for conflict of interest is financial.

Financial incentives could arise for organizations such as the V.O.N. and may be related to the type of payment received (fee for services provided versus salary for services provided).

With respect to the above, clearly a non-profit organization (e.g. - Board of Health or Health Department) which provides a service does not have the same potential conflict of interest as an organization which obtains revenues on a fee-for-services basis. In addition, if revenues are based on salaries, there is even less opportunity for conflict of interest when providing service and operating a service access organization at the same time.

Another type of conflict of interest may occur, on the part of an administrator who felt that the relative status of his position or organization would be enhanced, if the caseload and size of the program budget were increased. In such a case, this administrator might try to ensure that more patients are referred to his service. Of course, if this is an important issue, it is essential that checks and balances be in place to ensure separation between the S.A.O. and the service providers. (It should be pointed out, that such influence on the S.A.O. could be provided by administrators of any service providing agency. It is not an issues in the present Home Care Program).

Boards of Health are less likely to be influenced by this conflict of interest than any other organization, including new special purpose bodies. Boards of Health that operate Home Care Programs have a history of not directing inordinate services to its own staff. In addition, checks and balances are in place with Boards of Health to prevent this as there is clear separation between policy makers and staff. The addition of an appeal process can only add to this "impartiality" and, to the extent that Board members are elected officials, the public has additional direct means for addressing any perceived improprieties.

While Boards of Health are best positioned to be the S.A.O.'s, the changes in structure and composition needed would vary and would depend on the local situation (single municipal health departments), versus regional health units, versus county/district health units). However, the criteria to be an S.A.O. should not exclude present Boards of Health.

Conclusion:

In summary, the sponsor of a Service Access Organization has a hugely responsible role in the delivery of Long Term Care services. It is seen as part of improving communities' health in broad terms. Health Units are "on-line" philosophically with this approach to the provision of community health services and the promotion of well-being in the community. They have no financial stake in the outcome.

- There can be a clear separation between policy-makers and staff.
- There is the distance of an appeal mechanism.
- Boards of Health and Regional Committees have experience and facility in soliciting community input into programs.
- Boards of Health that operate Home Care Programs have a history of effectively and efficiently providing health services in the community.
- Elected officials on Boards of Health are directly accountable to their constituents.

The sponsor of the Service Access Organization must be accountable to the Province and the public to ensure that the resources at his disposal are deployed so as to receive the greatest benefit in line with the philosophy of the Province. Municipalities and Boards of Health have long histories of effective partnerships with the Provincial Government in such activities.

A.L.O.H.A. is prepared and pleased to accept the direction and challenges that are contained within the document. While the final outcomes may vary locally, A.L.O.H.A. firmly believes that health units are the most logical community organization to serve as the S.A.O.

(A copy of the draft report, entitled: Long-Term Care Reform Planning for the Future in Metropolitan Toronto (September 1990) from The Metropolitan Toronto District Health Council, is on file in the City Clerk's Department.)

4

A HEALTH AND SOCIAL ASSESSMENT OF THE SRI LANKAN TAMIL COMMUNITY

The Board of Health recommends:

1. **Adoption of the report (October 16, 1990) from the Medical Officer of Health.**

The Board of Health advises:

a) Having circulated the report (October 16, 1990) from the Medical Officer of Health to the Boards of Health in Metropolitan Toronto inviting their involvement and connection with the City of Toronto's program and urging that they consider strategies and programs in recognition of the Sri Lankan Tamil Community in their health units;

b) Having circulated the report (October 16, 1990) from the Medical Officer of Health to the Outreach Program at the Wellesley Hospital, with a request that they review its recommendations in terms of their future development;

c) Having requested the Department of Public Health to arrange for translation of the recommendations and a summary of the report (October 16, 1990) from the Medical Officer of Health, into Tamil.

The Board of Health extended congratulations and thanks to the staff of the Department of Public Health and all other persons who participated in the project.

Ms. Maria Lee, Department of Public Health, gave an oral presentation of the report.

The following persons addressed the Board of Health and, where indicated, submitted a written presentation:

- *Ms. Rosalind Rajanayagam*
- *Ms. Reetha Parthiban*
- *Dr. Raji Thurairajah (written submission)*
- *Mr. Thiru S. Thiruchelvam*

The Board of Health submits the report (October 16, 1990) from the Medical Officer of Health:

Origin: Medical Officer of Health, March 1, 1990 (c34hlth90117:345)

Recommendations: That the Board of Health endorse the following recommendations based on a health and social assessment of the Sri Lankan Tamil Community:

1. That the Department provide staff time, using a community development approach, to assist Tamils living in St. James Town and other areas in developing appropriate health services/programs.
2. That the Department reallocate funds to allow for flexibility to hire contract staff who will be able to help any new community to assess, organize and develop appropriate health services/programs.
3. That the Department approach external sources of funding to hire staff to work with this community's health needs.
4. That the Department, in collaboration with the City's Multicultural Access Program, develop a protocol to assess and facilitate health services for new arrival refugees/immigrants based on the experiences learned from the Tamil and South East Asian communities.

5. That the Department assist Access Alliance with the training of Tamil interpreters who will be included in their pool of interpreters.
6. That the Department translate pamphlets on key issues into Tamil in consultation with Tamil associations and work with these associations to distribute translated materials.
7. That the Department in association with the Tamil community sponsor a "Health Fair" or other promotional campaigns to raise the Tamil community's awareness of health issues and programs.
8. That the Department develop and implement new or expand existing programs to respond to the community's immediate need for prenatal and parenting programs.
9. That the Department investigate the possibility of upgrading skills of Sri Lankan qualified health professionals through training opportunities.
10. That the Department disseminate this report to other relevant agencies and organizations.

Comments: The Tamil community is one of the newest communities in the City of Toronto. The Department of Public Health recognized the need to establish links with the community and to do a health and social needs assessment of the community, in order to provide culturally appropriate public health services.

The Department hired, on contract, a Tamil Community Worker to conduct such a survey. Funding for the project was obtained from the City of Toronto Multicultural Access Program.

The methodology of assessment included: personal interviews with community leaders identified by the Community Worker; a consultation forum with Tamil and non-Tamil health and social service professionals; and questionnaires circulated to a cross-section of the Tamil community.

The attached report not only identifies the needs of the community but also recommends ways the Department can respond to these needs. The Department has already started to work with the community to develop appropriate resources and programs. Department initiatives include the following:

- The Downtown Health Area Management Team has assigned a Community Health Officer to work with the Tamil community living in the St. James Town area to assist them in developing community projects.
- Tamil interpreters have been trained by Access Alliance and are included in their pool of cultural interpreters available to Department staff.
- Department staff are working with a Tamil obstetrician to develop a pilot prenatal class for the Tamil community. A Tamil worker will be hired to cofacilitate these sessions with a prenatal teacher. The pilot project will give an opportunity to test content and methodology suitable for these seminars.
- Dental educational materials are being translated into Tamil.
- The Northern Health Area is beginning to plan a health fair in conjunction with the Board of the Tamil Co-op.

City of Toronto
Department of Public Health

Happy To Be Alive!
A Health And Social Assessment Of The Sri Lankan Tamil Community

P.R.W. Kendall, MBBS, MSc, FRCPC
Medical Officer of Health

March 1, 1990

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Executive Summary

The Health and Social Assessment of the Sri Lankan Tamil Community report is a vital step in designing a proactive response for the problems facing the 30,000 Tamils in Metro Toronto. Since 1983, most Tamils arriving in Canada have been refugees who have been forced to flee their country because of the political unrest.

The Public Health Department, City of Toronto, recognized the need to survey this cultural group in order to help design appropriate services. In September 1989, the Department contracted a Tamil community worker to conduct a health and social needs assessment of the community.

Information on the community was collected by interviewing about 45 key informants including community and service providers. Concurrently, questionnaires were collected from 204 Tamil community members. Also, a health consultation attended by about 50 community professionals and representatives from service and health agencies was conducted.

The results of the health and social assessment showed the many problems facing the Tamil community. Indeed, the crucial barriers to Tamils in Toronto identified were: language, inability to access mainstream services, lack of health awareness, lack of community and service support. Many of the concerns identified reflected the isolation and culture shock faced by Tamil refugees.

Immediate priorities of these individuals upon arrival include: employment, saving money, gaining landed immigrant status, and then sponsoring a family. Health needs and concerns appeared secondary. This does not reflect lack of need but rather displays the diverse needs of this community.

The Department of Public Health can play a significant role in helping to meet the health related needs of this community. The assessment demonstrated both the needs of the community and also the confidence that both Tamil and non-Tamil professionals have regarding the possible eradication of the health barriers. No doubt, the Department of Public Health will continue to play a significant role in broadening the health services available for the Tamil community.

The Tamil Community Health And Social Assessment

I Introduction

The Department of Public Health has a tradition of providing public health services to multicultural communities in the City of Toronto. The Department believes in reducing inequalities in the provision of health services, meeting the needs of its diverse population and providing support for new communities who find a home in our city.

It is in this context that the Department launched a two-fold program in order to ascertain the health and social needs of one of Toronto's newest communities, the Tamil community. The program's goals were:

1. To obtain a cultural profile of the Tamil community.
2. To conduct an assessment of the health and social needs of the Tamil community.

The Department hired a Tamil Community Worker in September 1989 for five months and entrusted her with the following mandate so that they could plan appropriate services for the Tamil community:

1) To locate members of the Tamil community living in Toronto,
2) To determine their health and social needs by means of a survey,
3) To identify key informants (Tamil and non-Tamil) who could provide social and health information on the Tamils,
4) To organize a health consultation involving representatives from the Tamil community, key informants, social agencies and the Department of Public Health, to further assess the health and social needs of Tamils, and
5) To formulate recommendations for the Department of Public Health.

II The Tamil Community - A Historical And Social Background

The Tamils, for the purpose of this report, are a minority group from Sri Lanka (formerly known as Ceylon)(See Map - Appendix A). Furthermore, the emphasis will be on Tamil refugees who came to Metropolitan Toronto between 1983-1989.

Ceylon is spoken of by early travellers such as Marco Polo as "an Idyllic island" in the Indian Ocean occupying the southern tip of the Indian subcontinent. Tamil is the language the inhabitants speak. The majority of Tamils are Hindus with a small percentage who are Christians. The island is divided into nine provinces, the northern and the eastern provinces have been the traditional homeland of the Tamils, as well as, Colombo, a capital city of Sri Lanka.

Sri Lanka has been under foreign rule for four hundred and fifty years before becoming independent in 1948. The last group to rule the island were the British. During British rule, English was the language of administration and the medium of instruction in secondary schools. In this period Tamils occupied the majority of senior government positions.

III Exodus Of Tamil Refugees To Canada

With the granting of independence in February 1948, differences between the Tamils and the Singhalese, the racial majority in Sri Lanka, began to surface. Hostilities reached a climax on July 25, 1983. Violence between Tamils and Singhalese brought masses of frightened Tamils to the shelter of refugee camps. The conflict spread throughout the Island and Sri Lanka soon became a country from where people fled as refugees.

Tamils who had family and relatives living in India, the United Kingdom, Australia, New Zealand or Canada, and could afford the financial burden of relocating, fled immediately to one of those Commonwealth countries. Several arrived in Montreal and Toronto asking to be reunited with their families. On September 14, 1983 the Canadian government introduced a special humanitarian program for the permanent reunification of family members still in Sri Lanka with those in Canada. Family class criteria was broadened to include uncles, aunts, nephews and nieces. Included in this political refugee group were bona fide Sri Lankan visitors on vacation in Canada. Their stay was extended and they were sponsored by relatives for permanent residence. The majority of the sponsored family class were educated in English and were able to find employment.

Further episodes of violence led Tamils to seek refuge in any country that would offer them asylum. Most had no relatives in Canada to sponsor them. A number found asylum in Denmark, West Germany, Holland or France. Though these countries provided the refugees with their basic needs of food, clothing and shelter, they denied them freedom of movement and freedom to work or study. Frustrated by these denials, many of the Tamil refugees began to look for places to land and became "refugees in orbit". Since Canada has a reputation of providing humanitarian treatment to refugees, hundreds of Tamil refugees began to land in Montreal and Toronto between 1984 and 1986.

The majority of Tamil refugees who arrived between 1985-1989 had very little exposure to the English language. They were educated after independence which stressed instruction in their first language. They have language problems compared to the earlier group who arrived in 1983-84.

IV Settlement In Toronto

In May 1986, during the influx, the Canadian Government was aware of the increasing human rights violations in Sri Lanka and adopted a practice of not returning any Tamil refugee claimants to their homeland. The (B1) list which the Canadian government introduced in May 1986 had named 18 countries including Sri Lanka to which refugees would not be deported because of human rights violations still rife there. Tamil professionals also joined the ranks of refugees because they could not return to their homeland on the termination of their employment contracts in Africa, the Middle East and the Caribbean. They were allowed entry into Canada on Ministers' permits and their better financial position enabled them to move to the suburbs. The majority of the Tamils living downtown however, moved into rooming houses or available apartments in the vicinity.

Metropolitan Toronto became the most popular destination for the Tamils. The figures from the Ministry of Immigration and Employment show the high correlation between the numbers arriving in Ontario and those choosing to locate in Toronto.

	Number of Sri Lankans 'Landed'	Those who Chose to Live in Metro Toronto	% of Total
1986	715	521	72.9%
1987	2476	2094	84.5%
1988	1726	1329	76.9%
1989 (Sept.)	1389	1205 (Approx)	86.7%

(Department of Public Affairs, Ontario Region, Department of Immigration and Employment, December 1989).

Within the Toronto area patterns of settlement began to emerge. On arrival most refugees lived in the St. James Town area and then moved on to Bloor/Lansdowne, Dundas West and Parkdale areas. The majority of Tamils living in the St. James Town apartments were single men. Married couples and those with families moved to Tuxedo Court in the Markham and Ellesmere area in Scarborough, Flemingdon Park, and Downsview in North York and Rexdale and Islington in Etobicoke. Some went as far as Mississauga. The 'Tamil Co-op Homes' on Bloor and Lansdowne (initiated by Tamil citizens and funded by both the Federal and Provincial Governments) provided several families with homes when it opened in the fall of 1988.

The majority of the refugees had suffered traumatic experiences in their homeland. Most came to this country with absolutely no preparation, expecting nothing more than freedom from the fear of arbitrary arrest and imprisonment. Many just wanted to get on with their lives which included finding employment. Some refugees were still financially supporting families left behind, repaying loans borrowed from friends and relatives who loaned them money for their flight to western Europe and their journey across the Atlantic to Canada. Many were hoping to become financially stable by working long hours, often at menial and low paying jobs. The Tamils were constantly concerned firstly about their status in Canada and the possibility of deportation, and secondly about their ability to bring their loved ones to Canada before they became victims of persecution and death in their homeland.

Talking a year later about the Tamil refugees who arrived in life boats off Newfoundland, Dr. Kingsley Ratnanather, a Tamil psychiatrist practising at North Western General Hospital in Toronto, said "the Tamils have adopted a quiet determined stance that is as much a reflection of inner strength as a psychological defence to the trauma they have suffered." Dr. Ratnanather continued, stating that "some of the refugees will eventually suffer from survivor guilt and deep down, even suicidal depression, when the reality of what has happened finally hits them in several years. For now, many are living on automatic pilot, their skills completely taxed by the daily challenges of working, eating and sleeping. Feelings of isolation and loneliness are deeply buried." (The Toronto Star August 10, 1987).

Reetha Parthiban, the Tamil counsellor for the Ontario Welcome House, added "if they mess up their lives here in any way, the family at home won't be able to move. Their chances of survival could be destroyed. They don't have that fun stage. Their teenage years are gone." (The Toronto Star Aug. 10, 1987)

As of February 1987 Sri Lanka had been taken off the list (B1) of countries "to which refugees should not be sent back." Deportation became a factor to contend with after that. Each refugee had to take full responsibility for proving to the refugee panel that he/she has a "credible basis" for claiming refugee status. The front line problem now is whether one will be allowed to stay in Canada or be sent back. As the anxiety grows, physical and mental health problems are bound to increase. Admission of more Tamils to the psychiatric institution on Queen Street has been noticed by Tamil hospital staff. A few cases of suicide among the young single men and women have been known in the community.

V Health and Social Needs Assessment

A series of needs assessment studies were conducted by the Tamil Community Worker hired by the Department of Public Health. The following is a description of the three methods used to obtain information:

(A) Key Informants

(B) Health Consultation

(C) Questionnaire

- How they were implemented
- The analysis of the data

A. Key Informants

Forty-five key informants, comprised of Tamil and non-Tamil medical and social service representatives, were contacted. The Contact Sheet (Appendix B) was designed by a team of Health Promotion staff members. It was filled in by the Tamil Community Worker either at a personal interview, or by a telephone interview. (List of key informants Appendix C)

Health Utilization Pattern Of The Tamil Community
As Perceived By The Key Informants

- Many were not accustomed to an annual medical check up and sought medical help only when ill.
- Several were not in the habit of keeping medical appointments. Family physicians often found it embarrassing when they made referrals to hospital specialists and the Tamil patient did not show up for the appointment.
- Using the telephone to make or to cancel appointments has not become a matter of routine for this group (possibly because of the language barrier).
- A dentist is visited only when an emergency arises and not on a regular basis.
- Women generally appear to be dependent on the male members of the family to escort them to the doctor, dentist or hospital.

- Though many Tamils follow through doctors' recommendations, a significant number ignore follow-up visits unless it is for their children. Tracking down patients who do not show up for their appointments is extremely difficult for the office staff especially when the patients move frequently.
- People who work two or three jobs obviously cannot find the time to visit doctors or dentists. Also, finding time for recreational activities and support services during regular hours is difficult. However, they do make use of medical facilities that are open until late in the evenings or on weekends. They prefer to visit a medical clinic where making an appointment is less threatening than a private doctor's office.
- Social interaction is usually with fellow Tamils. In a Tamil home they feel welcome and receive emotional support. They do not understand the Canadian way of life, and so are often isolated.
- Understanding of health issues, social issues and legal issues is hampered because literature available is not translated into Tamil.
- Their immediate priorities include: employment, saving money, gaining landed immigrant status, and then sponsoring a family.
- Learning English and integrating with the Canadian society is not important for some.
- A large number are healthy, but whether they could maintain good health without accessing available health services is doubtful.
- On the positive side, the professionals feel that the Tamils will avail themselves of services offered by the Department of Public Health if they had access to Tamil-speaking nurses and social workers.
- The Tamils are also prepared to travel across the City to consult a Tamil physician or one that is sensitive to their culture.
- It is quite common for those who cannot communicate in English to take with them a family member, a friend or neighbour fluent in English to interpret for them.

Health And Social Needs Of The Tamil Community As Perceived By The Key Informants:

Children

- Obtaining immunization status for the children poses problems for the school board.
- The family doctors to whom the school board refers such cases also find it difficult to get accurate information from the parents.
- The necessity for booster inoculations is not understood.
- Dental health is poor and parents do not seem to utilize dental services that are provided without cost to immigrant children within the first two years of arrival.
- Children have not been taught to brush their teeth after meals.
- Since parents are out of the home early in the morning, the children are left to make their own breakfast and pack a lunch, very often this might just be chips and pop.
- Young children are sometimes sent to school without adequate winter clothing.
- Matters of personal hygiene go unsupervised.
- Crowded living conditions make it difficult to have privacy.
- Communication with parents is very difficult unless done through a Tamil interpreter.

Youth

- In Sri Lanka, the Tamil youth tend to be well supervised by members of the extended family. Here they lack that support. The amount of freedom youth enjoy in Canada is a feature that Tamil youth are not prepared for, and some may misuse that freedom.
- The Tamil youth have not been exposed to sex education and the dangers of substance abuse.
- Opportunities for recreation and social interaction are lacking.
- Some cases of learning disability have been identified, which need to be addressed without delay.
- Loss of self esteem must be recognized as a serious social problem.

Adult - Men

- Alcoholism is the most commonly identified problem.
- They are unaware of the risks of smoking.
- They do not realize the importance of annual medical check-ups.
- They suffer from loss of self-esteem because of unemployment or under-employment, resulting in depression and family quarrels.
- Helping the wife with the household chores is not something they are accustomed to doing.
- Diabetes and hypertension have been mentioned as health problems.
- Nutritional problems are common. They need diet counselling as well as an exercise program.

Adult - Women

- Prenatal and postnatal problems have been identified.
- Women suffer most from the lack of traditional family support.
- They have very little knowledge of health education.
- They need assistance to understand the Canadian way of life, i.e., how to prepare nutritional meals for the family and dress their children suitably.
- Thyroid problems seem to be common.
- Annual physical examination, self breast examination and PAP smears are not looked upon as necessary.

Seniors

- Many elderly experience loneliness and social isolation in Canada.
- Apartment living is foreign to them. It increases the feeling of being shut in.
- They are dependent on their children to take them out to the doctors, to the shopping centres, or to visit relatives and friends.
- Diabetes, arthritis, hypertension seem to be common problems of the elderly as is poor nutrition.
- Many of them help at home, specifically with baby sitting.
- Problems of social adjustment occur especially with in-laws, who often share the same crowded apartment/house.

Suggestions From The Key Informants For Solving Some Of The Tamil Health And Social Problems

- That the Department of Public Health recruit community workers who can speak Tamil to help with counselling, as well as to assist with accessing existing resources.

- That trained Tamil interpreters be available for home visits with the Public Health Nurse. This could be worked out with the assistance of Tamil organizations.
- That literature on health education be provided in Tamil.
- That Tamil functions be organized through local churches, temples, etc., in conjunction with the Department (Health Fairs) to increase awareness.
- That the development of a support system specifically for pregnant Tamil women at high risk, and for the elderly.
- That mental health awareness and treatment facilities should be made known through the Department and existing Tamil organizations.

The forty-five key informants, in spite of varying backgrounds, were unanimous in identifying needs: the language barrier, lack of understanding of the health care system and lack of knowledge in preventive care. They all felt very strongly that the Department had an important role to play in providing preventive services and highlighting risk factors. If the Department needed support, the key informants said that they would be only too pleased to assist.

B. Health Consultation

The Tamil Community Health Consultation was held in City Hall on November 27, 1989. The 50 participants invited to the consultation included representatives from the medical profession (family physicians and psychiatrists), the Board of Education, Metropolitan Toronto Police (Ethnic Relations Unit), Ministry of Housing, Immigration and Employment, Citizenship, Social and Community Services, along with the Department of Public Health and the Tamil community leaders.

The objectives of the consultation were:

1. To identify the health needs of the Tamil Community,
2. To formulate recommendations for the Department and other agencies to plan more appropriate services for the Tamil Community.

This Consultation was a significant event for the Tamils. For the first time, a major health care provider in Toronto was consulting them about the health and social needs of their community. This was the first time a health needs survey had been implemented exclusively for the Tamil population.

Presentations were made by a Ministry Coordinator of Medical Services, an Ontario Welcome House Counsellor, an obstetrician-gynecologist and a psychiatrist. All four speakers were Tamils and were familiar with the cultural background of the Tamils and the challenges they faced trying to settle down in a new country. (Consultation proceedings in Appendix D).

i) An Overview Of The Health Needs Of The Tamil Community

Dr. Nesamoni Lysander, who is the Coordinator, Health Services, with the Ministry of Community and Social Services, Ontario, said, "ethnic health care must have three basic principles, i.e., community orientation, comprehensiveness and cultural sensitivity."

According to Dr. Lysander the people who receive services should have a say in deciding:

1) what kind of services are to be offered;
2) where they are to be offered; and,
3) when they are best offered.

"Failure to involve the community will lead to poor utilization of services" said Dr. Lysander. "Effective utilization of community health services", he said, "will be easier if provided in a non-threatening manner." The Tamil community functions best in a less threatening informal setting. The main threatening barriers he identified were organizational and bureaucratic, geographical, psycho-social, and time barrier.

For the Tamil people, the family unit is the most important part of support and strength to the individual. Therefore effective community health care must reflect the needs of the individual as well as the family. He suggested the following:

1. Personal and Family Health Counselling and Education services be provided within an existing community health module for:
    - Resolving issues related to personal and family health
    - Communicable disease prevention
    - Immunization status and records maintenance
    - Nutritional guidance
    - Reproductive and sexual health counselling and treatment
    - Dental health - prevention, education and treatment
    - Personal health habits - hygiene
    - Maternal - prenatal counselling and child health guidance
2. Environmental Health
    - Healthy living environment at home
    - Worker's Compensation issues
    - Pollution and the individual's role in prevention
3. Psycho-social Health
    - Mental health services
    - Family violence prevention
    - Substance abuse prevention

He stressed that "Effective health care, to be acceptable, should be culturally oriented. Cultural sensitivity is vital in preventive, curative and rehabilitative health care services. Persons from the same ethnic background and culturally empathetic will be more effective in serving the Tamil people than others". He also suggested that educational programs on community health could be presented through appropriate religious bodies (Appendix C) since the Tamil have a strong affiliation to religious identity, and would seek help through religious institutions.

ii) Social Service Needs Of The Tamil Community

Reetha Parthiban, Settlement Officer with the Ontario Welcome House, Scarborough, stated that her main concern was not the adequacy or inadequacy of services, as much as the barriers ethnic groups experience in accessing those services.

She identified several barriers, such as language, information, culture and staffing.

She said that some Tamils have a good command of the English language, while others have limited English language skills. Most of the recent refugees need to learn the new language because these language skills are instrumental in adapting to Canadian culture.

Ms. Parthiban stressed that the Tamils are unaware of available services not only because they often have no access to them, but also when translated it often does not reach the people who need it most. Lack of linguistically and culturally sensitive staff prevent newcomers from accessing available and valuable services.

She also cited that seeking help outside the family is a new concept for the Tamils. If their beliefs and practices are not understood, interpersonal problems would be difficult to solve.

She emphasized the importance of knowing the pre-immigration status of their clients to understand class differences of the Tamils. Generalizing and stereotyping can cause unfounded prejudice and discrimination. The social needs of the different groups will vary according to their pre-immigration status. These differences must be taken into account both when Public Health Nurses work with their clients, and before the Department of Public Health provides a new service.

Ms. Parthiban's suggestions for improving social needs are:

- To provide employment opportunties for the different cultural communities,
- To develop leadership sklls in the ethnospecific organizations so they are able to play an important role in the link between the mainstream and ethnospecific organization,
- To initiate bilingual programs, e.g., pre-natal classes, mom and tot, battered women,
- To provide education material and seminars on relevant issues, e.g., power of the union, Worker's Compensation, industrial hazards, employment opportunities,
- To start group discussion to deal with teenagers', women's, men's and seniors' problems,
- To train ethnospecific organizations on conflict resolution and mediation, to handle family violence, and to work in collaboration with qualified marriage counsellors,
- To have central access to funding information for ethnospecific organizations,
- To have internships for ethnospecific organizations to have volunteers trained with the mainstream organization and for the mainstream organization to have their workers spend a certain number of hours with the ethnospecific organization,
- To advocate for improved services such as daycare, affordable housing and support groups.

iii) Maternal And Child Care Needs

Dr. Raji Thurairaja, an Obstetrician and Gynecologist with Queensway Hospital, Etobicoke, identified three problems from her experience with Tamil patients in Toronto. They faced a language barrier; cultural differences in maternity care and child care; and lack of knowledge of available resources.

Dr. Thurairaja cited that the reason for not seeking medical care during normal pregnancy is because pregnancy is considered a normal event and not an illness. To a group of people who utilize medical services only "when the need arises" regular visits to the doctor during pregnancy do not appear to be necessary. Parents, grandparents, aunts and even good neighbours will offer support to the pregnant woman, who enjoys a special status in the family. Prenatal education is not given by health professionals in formal classrooms but through advice and informal counselling on a daily basis by senior members of the community or trained midwives who also carry out periodical visits. This practice makes the pregnant Tamil woman in Canada wonder why she should see a doctor so often.

Dr. Thurairaja also pointed out that in the Tamil culture, labour and delivery are considered a female domain, and husbands seldom get involved. The greatest fear that a Tamil woman in Canada, pregnant for the first time faces is how she will get through the whole ordeal without traditional family support. This will certainly be a concern for the Department of Public Health. It would be just as important for a Tamil Home Visitor to do prenatal visits as postnatal care. Unlike many Canadian women, the Tamil women are ignorant of the human anatomy and the changes that are taking place in their bodies during pregnancy.

When her doctor asks her to make decisions, a Tamil woman is at a loss to answer because in her culture "the doctor knows best" and decisions are usually made with the help of family members.

Attending prenatal classes with their wives is not a common practice for the Tamil men. The young Tamil mother faces the frightening ordeal alone in a new country; lack of English complicates the situation and adds to the stress she is already under.

Dr. Thurairaja said that caring for a baby is just as difficult without family support. With the new practice of early discharge from hospitals, the new mother will need greater support. She said that the Department of Public Health could consider the following suggestions to help the new mother:

- Organizing self-help or support groups,
- A counselling service utilizing health care personnel and members of the Tamil community,
- Providing a hotline for answering questions, especially during crisis situations,
- Informing mothers of existing resources relevant to their situation,
- Providing a central Tamil Information Centre to which Tamil clients can be directed,
- Encouraging Tamil mothers to learn English as soon as possible.

iv) Mental Health Needs

Dr. Janaki Srinivasan, a Specialist in Psychiatry with North York Branson Hospital recognized the fact that there is a definite and steady increase in the number of Tamil patients she was seeing in the hospital and in her office. This could be as a result of increased awareness, on their part, or their inability to cope with greater demands made by society. She identified the following reasons for an increase in mental health problems:

- Culture shock
- Financial difficulties maintaining a suitable standard of living
- Climatic conditions
- Language barrier
- Facing the stigma of being a refugee in Canada
- Sense of alienation due to a feeling of losing all their ties with their homeland
- The discrepancy in their expectations and actual accomplishments.

Dr. Srinivasan noted an increase in domestic violence, as a result of "marital dysfunction". Psychotic illnesses and depression were common forms of mental illnesses to a group suffering from traumatic experiences in their home country. Alcoholism appeared to be a problem associated with depression. Her great disappointment in treating the Tamil patients, said Dr. Srinivasan, "is their failure to cooperate with the doctor after initial assessment. They do not follow through with the recommendations of the doctor. This group often is highly resistant to treatment suggestions, and often are very hesitant to seek any guidance". Belief in fatalistic theories may be one reason for this behaviour. The culturally-based stigma of mental illness, as well as the "lack of sophistication in help-seeking efforts" might be additional reasons for not seeking treatment, said Dr. Srinivasan.

Her suggestions for improving service to overcome resistance and denial:

- Provide interpreters in hospitals and other settings to overcome language issues, misunderstanding in diagnosis and other issues which commonly occur,
- Improve community support,
- Provide educational support for children and youth before they are actually enrolled, to overcome shock, humiliation and loss of self esteem caused by poor performance,
- Upgrading of English and mathematics skills are particularly important,
- An outreach group at community level, through paramedical support may be instituted, as current resources are inadequate,

- **Public Health awareness regarding alcohol and drug related problems, mental and physical disorders could be provided through information in the Tamil language.**

v) Discussion Groups:

Discussion groups that followed the consultation provided further suggestions for helping the Tamils with their health and social needs:

- An awareness of public health issues ranging from child care, sex education, and drug abuse to physical cleanliness and upkeep is essential. The best way to achieve this would be through a process of education using the T.V. program "Asian Horizons" which Tamils watch on a regular basis. This would be a suitable time to introduce health education.
- Culture shock and extreme sensitivity of parents, prevent the children and youth from receiving information on topics like sex education, dangers of sexually transmitted diseases and AIDS. Culturally sensitive health educators along with medical/social leaders from the Tamil Community should explore ways of teaching these topics, that will be acceptable to the community.
- There is a great need to organize prenatal classes in Tamil. Classes should be held in a central location (e.g., Tamil Co-op Homes in the Bloor and Lansdowne area).
- Tamil doctors and nurses who have professional training and experience from their home country and can speak both English and Tamil could be considered for training as prenatal educators.
- A team of male and female prenatal educators should conduct the prenatal classes so that both mothers to be, as well as fathers to be, can feel free to ask question.
- Organize well baby clinics in Tamil.
- Arrange for central interpreting services.
- Publicize information on health and social issues in Tamil through the radio, T.V. and printed materials.
- Educate people on health problems like Drug Abuse, Sexually Transmitted Disease (STD), A.I.D.S. through the E.S.L. classes.
- Methods of delivery of health information: places of worship, Tamil stores, neighbourhood information centres, Tamil Physicians/Psychiatrists' offices.

C. Questionnaires

A structured questionnaire was designed by the Health Promotion and Advocacy Section of the Department of Public Health for the purpose of collecting demographic information and assessing the health care and social needs of the Tamils (Appendix E). The questionnaires were in English and Tamil. A total of four hundred questionnaires were distributed through community leaders as well as Tamil organizations from October to December 1989. Two hundred and four questionnaries were returned.

The Tamil survey had its constraints with time as well as methodology. Random sampling was not possible for lack of an adequate sampling frame or any official demographic information. Areas of obvious geographical concentration were used to distribute the questionnaires. Meeting the Tamil residents in groups in the evenings, for the purpose of administering the survey became difficult because of job commitments for the men. Women and seniors could not attend because there was nobody to escort them. Baby sitting problems were faced by many. In some instances, the Tamil Community Worker left the questionnaires in offices of key informants who volunteered to distribute and collect them when the Tamil patients/clients visited them. The T.T.C. strike at the beginning of the survey period affected the attendance at meetings of Tamil associations called to prepare the community for the survey.

Filling a questionnaire personally was a new experience to many Tamils. In retrospect, a personal interview in an informal setting, with the Tamil worker writing down responses later would have been a better method.

Though it was made clear that the information given would be kept strictly confidential, some Tamils have an underlying fear that whatever was written might affect their chances of being allowed to stay in Canada. Many Tamils withheld information because of fear. Gathering information is looked upon with suspicion, because information given has been used against them at home.

A representative picture of the Tamil's health and social needs could not be obtained from this survey because of the non-random sampling method, and the low response rate to the survey. However, we could consider this as a pilot study which is able to shed light on the Tamil Community's needs. Future studies of the same topic with basic planning parameters, could be undertaken at a later date.

Survey findings from the 204 returned questionnaires are summarized:

Personal Data

- 73.5% of the 204 Tamil people were aged 20-54, 13.2% aged 55-64, and 5.9% are aged 65 and over, only 5.4% were younger aged below 19.
- 56.9% of them are male and 43.1% female. *68.1% of them were married. 25.0% single, and 6.9% widowed. *(Some single men were married and their spouses and children were left in Sri Lanka and they need to be sponsored).
- 55.4% of them speak both Tamil and English, 37.3% speak Tamil only, and 1.0% other languages. This suggests that at least one-third of the respondents cannot communicate well in the Canadian society due to language barrier.
- 41.7% of them resided in the City of Toronto, 37.3% in Scarborough, 14.7% in North York, and 6.4% in other areas.
- The majority of the respondents are newcomers to Canada; 60.4% of them arrived in Canada between 1985 and 1989, 13.3% between 1980 and 1984, and the remaining prior to 1980.

Medical Needs

- Only five of them did not have OHIP; and 15 did not have a family doctor. Essentially they are all covered by the health care system at the basic level. Major reason for not having a family doctor is "do not know whom".
- 68.1% of them visit a doctor only as need arises, 13.7% see a doctor periodically, 12.7% on a regular basis, and 5.4% gave no answer to the question.
- Although being covered by the OHIP, the respondents have not made much use of medical services so far. The group reported only 115 visits to private doctors, 53 in patient admissions, 32 times outpatient treatments in hospitals, 24 visits to clinics, and 29 episodes of emergency room services since their arrival in Canada.

Dental Needs

- 41.4% of them had a dentist. Most of those who had, would visit dentists only as the need arose.

Use of Public Health Services

- About one-half of the respondents did not answer the questions on whether it is easy or difficult to obtain public health information regarding child care and immunization, nutrition, STDs and communicable diseases, smoking, alcohol, drug use, AIDS, and stress problems. This indicates that public health information is not a familiar subject for the Tamil Group.
- Of those who answered the questions, about two-thirds thought it was easy to obtain information on prenatal service, dental health, nutrition, immunization, birth control, cessation of smoking, use of alcohol and drugs.
- On the other hand, slightly over half of those who answered the questions thought it is difficult to obtain information on raising children, infectious diseases, stress and emotion, sexually transmitted diseases, AIDS, and elderly health.

- The three major difficulties for obtaining public health information as suggested by them are, in a descending order, "pamphlets not available", "did not know how to go about it", and "lack of time".

Risk Factors

About one-fifth of them did not answer the questions on risk factors. Of those who answered, the majority reported not having the risk of:

- overweight (84.7%)
- high blood pressure (89.8%)
- heart troubles (94.8%)
- arthritis and rheumatism (85.3%)
- asthma (95.9%)
- depression and anxiety (94.7%)
- anaemia (97.1%)
- diabetes (89.0%)

These findings suggest that the perceived health status of those who answered the risk factor questions is good. However since one-half of them did not answer these questions, it is difficult to see the whole picture of the perceived health status of the respondents.

Housing

- 56.9% of them lived in apartments, 16.7% in single family dwellings, 13.2% in rented rooms, 3.9% in basement apartments, and 3.9% in condominiums.
- 75.0% of them rented their place of residence, 18.1% were owners, and 6.9% gave no answer.
- 75.5% of them lived with their families, 13.2% with friends, 4.9% lived alone, and 6.4% gave no answer.
- In regard to the adequacy of their living place, 62.7% felt adequate, 18.1% felt crowded, and 19.1% gave no answer.
- About half of the respondents did not answer the questions of heating and ventilation of their housing.
- Of those who did, almost 90% thought their houses were well heated and the same percentage thought their houses were well ventilated. Again, the large number of 'no' answers makes it difficult to arrive at a concrete conclusion.

Support System

- Excluding those who did not answer the question, 61.7% of the Tamil group thought they had an adequate support system.
- The major sources of support are, in a descending order: family, friend, parents, public health nurses, Tamil organizations, minister of church and the Welcome House.

Employment

- 65.7% of the respondents reported having employment, 28.4% did not have a job, and 5.9% gave no answer. Of those who worked, 68.8% enjoyed job satisfaction whereas 22.2% did not.
- Of those who worked, the three most popular ways of finding employment are: through friends (32.8%), through newspaper advertisements (29.8%), and through employment agencies (28.4%).

- 51.5% of those who work spent one to two months to get a job, 23.8% spent three to six months, and 26.2% spent six months or more.
- 82.8% of those who worked, are on day shift, and 17.2% on night shift, almost all worked eight hours a day. Only 13.4% said that they worked weekends.
- The common job concerns expressed by the Tamil group are shown in a descending order as follows: low pay, job security, (not well equipped), no prospect, difficult to seek job, and irregular working hours.
- Of those who answered the questions on health hazards and occupational safety, 57.9% were aware of the former and 62.2% of the latter.

D. Analysis Of Data

The health and social needs of the Tamil community which were identified by key informants and speakers at the health consultation were based on observations and first hand experience of the professionals. The Tamil health questionnaires, on the other hand reflected opinions of Tamils who are users of health services and many new arrivals, who had a very limited knowledge of the medical health and social services available in Toronto.

The language barrier was identified by the professionals as a primary obstacle for Tamils in accessing services. Family physicians emphasized the need to provide Tamil interpreters and printed health information in Tamil. They also highlighted the need for health care counsellors, community workers and public health nurses who can provide services that are culturally sensitive and ideally Tamil speaking.

The majority of Tamils who answered the questionnaire did not directly identify lack of English as a barrier although 37.3% said that they spoke only Tamil. 55.4% perceived themselves as having the ability to speak both Tamil and English. It is speculated that although many Tamil refugees have some exposure to English in their schools at home, that their knowledge may not be sufficient for them to function in a society where English is the first language.

The Tamil community do not usually schedule routine check-ups for physical and mental health maintenance. They visit their physicians only when they are ill. To them health maintenance does not seem to be an important practice. The professionals feel that risk factors can best be identified during annual physical examination rather than during the onset of an acute illness.

The Public Health Department and the role it plays in providing preventive services is not familiar to the Tamils. When asked the reasons why obtaining health information was difficult, their replies were "did not know how", "pamphlets not available in my language", "do not have a Tamil interpreter", "do not have the time".

The professionals were deeply concerned about follow-up visits of their Tamil patients. One of the psychiatrists interviewed was upset to find that Tamil mental health patients were unaware of the importance of following through with treatment suggestions. Mental illness had a social stigma and the cause of illness could only be attributed to fatalistic theories and so did not justify ongoing treatment. They were also unaware that with modern drugs, the chances of the patients returning to normal life were high.

The risk factors identified by the professionals were overweight, high blood pressure, diabetes, depression, etc. Interestingly, the Tamil patients did not see themselves at high risk in these areas. Indeed, their perceived health status was good, and they did not feel the need to find family doctors or visit them routinely.

The professionals appear to have high expectations for their Tamil patients such as, learning to maintain good health, becoming aware of existing health and social services, utilizing those services to their advantage, and overcoming the obstacles of language by learning English as soon as possible. They felt that in the interim, service providers should be requested to assist the Tamil community with Tamil interpreters, health education in Tamil, through Tamil pamphlets, radio and T.V.

Affordable housing, daycare, unemployment/under-employment were considered as important social needs by the professionals; however, these areas were not identified by Tamil refugees. Safety rules and health hazards were not identified by Tamils as areas of concern, but industrial accidents had occurred because of lack of experience and training in using sophisticated machinery. The key informants often have Tamil patients come to them regarding Worker's Compensation issues and matters that affected their occupational safety.

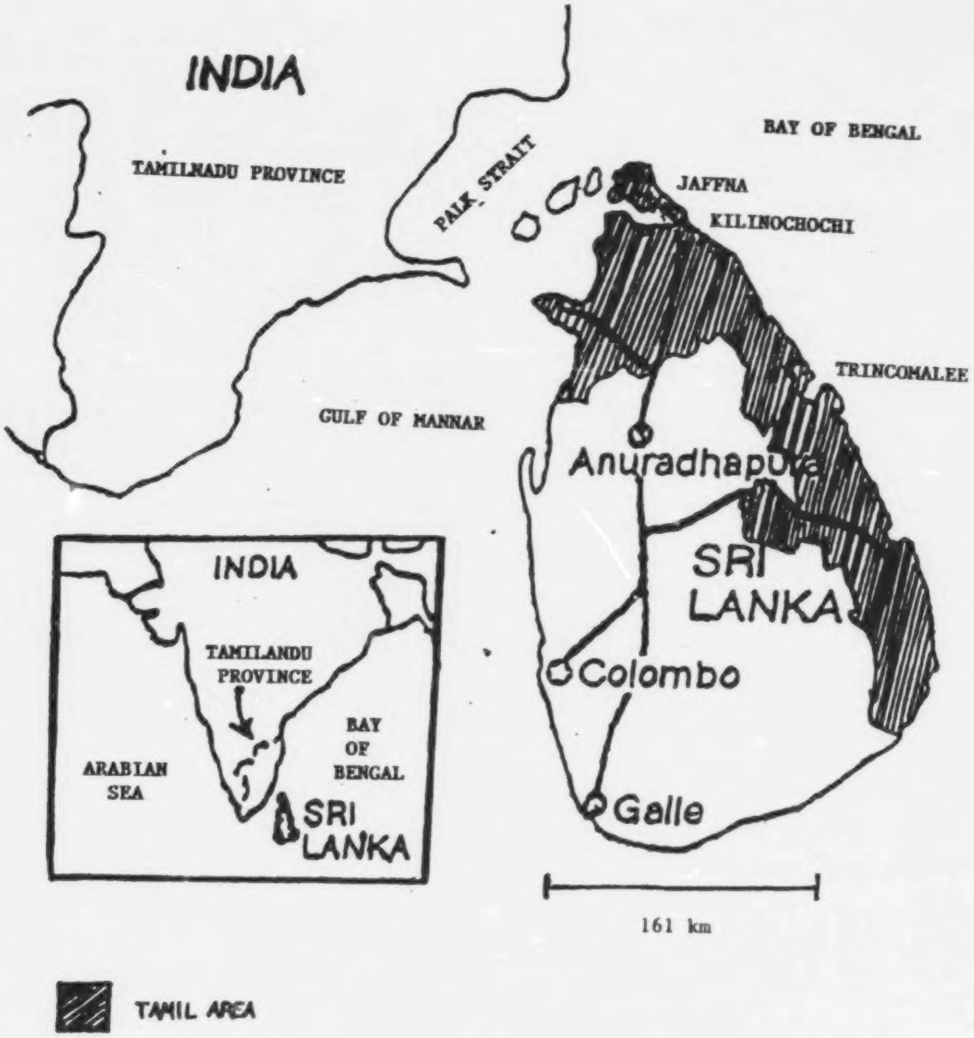
There is a difference in the expectations that the professionals have for the Tamils and what the Tamils perceive to be necessary to maintain good health. This could be due to the small number of people who answered the questionnaires. The issues of health prevention are not seen as priorities. Right now, many are just too busy securing basic survival needs and are 'Happy to be Alive'.

Recommendations:

1. That the Department provide staff time, using a community development approach, to assist Tamils living in St. James Town and other areas in developing appropriate health services/programs.
2. That the Department reallocate funds to allow for flexibility to hire contract staff who will be able to help any new community to assess, organize and develop appropriate health services/programs.
3. That the Department approach external sources of funding to hire staff to work with this community's health needs.
4. That the Department, in collaboration with the City's Multicultural Access Program, develop a protocol to assess and facilitate health services for new arrival refugees/immigrants based on the experiences learned from the Tamil and South East Asian communities.
5. That the Department assist Access Alliance with the training of Tamil interpreters who will be included in their pool of interpreters.
6. That the Department translate pamphlets on key issues into Tamil in consultation with Tamil associations and work with these associations to distribute translated materials.
7. That the Department in association with the Tamil community sponsor a "Health Fair" or other promotional campaigns to raise the Tamil community's awareness of health issues and programs.
8. That the Department develop and implement new or expand existing programs to respond to the community's immediate need for prenatal and parenting programs.
9. That the Department investigate the possibility of upgrading skills of Sri Lankan qualified health professionals through training opportunities.
10. That the Department disseminate this report to other relevant agencies and organizations.

APPENDIX A

SRI LANKA HOME OF THE TAMILS



Appendix B

Tamil Community
Need Assessment

Key Informants - Contact Sheet

A.

Name:

Position:

Organization/Agency:

Address:

Telephone:

Date:

B. Contact With The Tamil Community

1. Does your department/agency/office have contact with members of the Tamil Community on a regular/ad hoc basis?
2. How often?
3. Do they come to you voluntarily/on referral?
4. Approximately how many would you contact in a week/month/year?
5. Where do your clients live? (Give a general idea of their residence)
6. Is the number of clients you see increasing/decreasing/steady since 1983?
7. What do you perceive to be the health needs of the Tamil Community?

   Children:

   Youth:

   Adult Men:

   Adult Women:

   Seniors:
8. How do you help fulfill their health needs?

   Children:

   Youth:

   Adult Men:

   Adult Women:

   Seniors:
9. What are the health problems (needs that cannot be fulfilled) for your clients.

	Problem	Ways Suggested to Solve
Children		
Youth		

Adult Men

Adult Women

Seniors

10. Do you see any obstacles in your clients communicating with you?

11. How can these obstacles be overcome, suggest ways:

C. 12. What resources are you presently using to serve your clients?

13. Can you identify any other person I can talk to regarding the health needs of the Tamil community?

14. Can the Department of Public Health play a role in helping to alleviate health problems of your clients:

Suggest how:

15. Remarks

Thank you for your cooperation

Appendix C

Key Informants

Who gave personal interviews
on the health and social needs of the Tamil Community

Dr. Elizabeth George	- Family Physician, Ellesmere Scarborough
Dr. Raji Thurairaja	- Obstetrician-Gynecologist, Queensway Hospital, Etobicoke
Dr. Sunita Nandi	- Family Physician, Neilson Avenue, Scarborough
Dr. Jeya Edwards	- Family Physician, Eglinton Avenue West, Toronto
Dr. A. Srinivasan	- Family Physician, Agincourt, Scarborough
Dr. M. Nadaraju	- Family Physician, Boniface Medical Centre, Scarborough
Dr. Francisco Portugal	- Family Physician, St. James Town, Toronto
Dr. Ann Tsang	- Family Physician, Roncesvalles Avenue Toronto
Joan Simalechik	Director, Canadian Centre for Victims of Torture
Dr. Andrem Lam	- Family Physician, Roncesvalles, Toronto
Dr. Raj Sivendra	- Dental Surgeon, Parkway Mall, Scarborough

Dr. Janaki Srinivasan	- Psychiatrist North York Branson Hospital
Reetha Parthiban	- Settlement Officer, Ontario Welcome House
Jacob & Hilda Thangarajah	- R.N.'s, East General Hospital
Kanages Nadaraja	- Multicultural Assessment Project Worker, Toronto Board of Education
Jennifer Khong	- Cityplan '91, Toronto
Jody Rajalingam	- Riverdale Immigrant Women's Centre
Luna Ramkhalawansingh	- Community Development Officer Municipality of Metro Toronto
Dr. Bea Ashem	- Psychologist, Community Preventive Health Section Department of Public Health
Dr. Mary Kudrac	- Supervisor, Dental Services, Northern Health Area Department of Public Health
Nancy Parker	- Personal Health Services Nursing Supervisor, Northern Health Area Department of Public Health
Carolyn Cruickshank	- Personal Health Services Nursing Supervisor, Western Health Area Department of Public Health
Parames Kanapathipillai	- Tamil Home Visitor, - "Parents Helping Parents"
Jean Rehder	Public Health Nurses, Downtown Health Area, Team 2
Cindy Vasey-Harewood Fanchea Knoll Annemarie Kane Sheila Lippiatt Amy Yau	
Karen Whitworth	- Personal Health Services MDT Supervisor, Downtown Health Area
Anjana Murthy	- Women's Shelter Worker, Samaroo House
Joyce Boucher	- Principal, Rose Avenue Public School, Toronto
A. Sivanandan	- Caretaker, 375 Bleecker Street

People Who Gave Telephone Interviews on The Health and Social Needs of the Tamil Community

Dr. Brenda Kumar	- Family Physician, Rosedale Medical Centre, Toronto

Dr. D. Jegatheeswaran	- Family Physician Grace Hospital, Scarborough
Dr. Katie Driver	- Family Physician, Sick Children's Hospital, Toronto
Miss Parsons	- Public Health Nurse, Queen Victoria Public School, Toronto
Maria Devereaux	- E.S.L. Teacher, Winchester Public School, Toronto
Amina Vania	- Tuberculosis and Respiratory Nurse Northern Health Area
Amina Velani	- School Community Relations Worker, Toronto Board of Education
Dr. Kingsley Ratnanather	- Psychiatrist, N.W. General Hospital, Weston
Dr. Anita Hunt	- Family Physician, Mississauga

Appendix D

Agenda

Tamil Community Health Consultation
November 27, 1989 — 1:00-4:30 p.m.
Committee Room 6, City Hall

1:00 p.m.	Registration
1:15 p.m.	Introduction - Maria Lee (Chair)
1:20 p.m.	Welcome - Perry Kendall, Medical Officer of Health.
1:30 p.m.	Presentations: 1. Overview of health needs of the Tamil community (Dr. Nesamoni Lysander). 2. Social Services & Community needs (Ms. Reetha Parthiban). 3. Maternal and Child Care Needs (Dr. Raji Thurairaja). 4. Mental Health Needs (Dr. Janaki Srinivasan).
3:00-3:15 p.m.	Break
3:15-4:00 p.m.	Small group discussion and recommendations Group 1 - Ken Kandeepan, Facilitator Eucharista Tambipillai, Recorder Group 2 - Kanages Nada - Facilitator Malar Jeeva, Recorder Group 3 - Parames Kanapathi Pillai, Facilitator Sothy Sinnathamby, Recorder Group 4 - Jody Rajalingam, Facilitator

Beatrice Arnold, Recorder

4:15 p.m.	Summary of recommendations
4:30 p.m.	Closing remarks

Tamil Community Health Consultation Participants
November 27, 1989 - City Hall

Name	Organization
Beatrice Arnold	Wife Assault - Tamil Interpreter
Bea Ashem	Psychologist - Department of Public Health
Fred V. Balasingham	Refugee Information Centre
Mutale Chanda	City of Toronto Multicultural Access Program
Karen Chiu	AIDS Prevention - Department of Public Health
Constable Derek	Ethnic Relations - Metro Toronto Police
V. Facciolo	Community and Social Services
Paul Fleiszer	Department of Public Health Northern Health Area
Martha Hackney	Department of Public Health Eastern Health Area/ Downtown Health Area
Maria Herrera	Department of Public Health Health Promotion and Advocacy Section
Malar Jeeva	Toronto Board of Education
Denise Jeffers	Metro Toronto Housing Authority
Sam Jeyatheva	Senior Tamils
Joseph Kalath	Metro Toronto Children's Aid
Jennifer Khong	Planning and Development Department Cityplan '91
Ken Kandeepan	Society for the Aid of Ceylon Minorities (SACEM)
Dr. I. Kumaradeva	Tamil Community Member
N. Kumaradeva	Tamil Community Member
Yuri Kuzmyn	Canada Employment Centre
Maria Lee	Department of Public Health Health Promotion and Advocacy Section
Cathy Lees	Canada Employment Centre

Tim Little	Metro Toronto Housing Authority
Maria Lo	Riverdale Immigrant Women's Centre
Dr. N. Lysander	Provincial Co-ordinator, Medical Services, Ministry of Community and Social Services
Ursula Mathes	Metro Toronto Housing Authority
Paul Meagher	Department of Public Health
A. Mahendiran	Tamil Co-op Homes
A.K. Murthy	Battered Women's Shelter
K. Nada	Toronto Board of Education
Sritharan Nathan	Tamil EELAM Society
K. Parameswary	'Parents Helping Parents'
Nancy Parker	Department of Public Health Northern Health Area
Reetha Parthiban	Ontario Welcome House
Dr. F. Portugal	Family Physician (St. James Town)
Faiz Rahman	Toronto Board of Education
Rosalind Raja	Tamil Community Worker Department of Public Health
Jody Rajalingam	Riverdale Immigrant Women's Centre
S.V. Rajanayagam	Tamil Christian Church of Canada
Jean Rehder	Department of Public Health Downtown Health Area
Kamala Shanmuganathan	Tamil Community Member
Constable Shuk	Ethnic Relations - Metro Toronto Police
Sothy Sinnatamby	Tamil Community - RNA
Dr. Janaki Srinivasan	Psychiatrist - North York Branson Hospital
Dr. H. Stuart	Chairperson - Multicultural Task Force Department of Public Health
Constable Syed	Ethnic Relations - Metro Toronto Police
E. Thambipillai	Toronto Board of Education
S. Thiruchelvam	Tamil EELAM Society
Dr. Raji Thurairajah	Obstetrician - Etobicoke
Ramie Veerappan	Amalgamated Nursing Agency
Chee Wong	Department of Public Health Health Promotion and Advocacy Section
Maureen Wooding-Thornhill	Scarborough Health Department

Carole Yawney	Atkinson College - York University
Pamela Youssef	York Region Public Health Department

Introduction By Maria Lee

Good afternoon, Dr. Kendall, speakers and guests from the Tamil Community, Representatives from various community and service agencies and Colleagues from the Department of Public Health, honoured guests, ladies and gentlemen:

Thanks for taking time from your busy schedule to participate in this important health consultation. This is the first consultation in the Tamil Community of this nature. My name is Maria Lee, Supervisor of the Health Promotion and Advocacy Section, Department of Public Health.

I am going to chair this meeting this afternoon.

Before we start the proceeding today, I would like to take this opportunity to give you a bit of background to the history of this project.

The idea of conducting a Tamil Assessment project was initiated by the Departmental Multicultural Task Force on Access to Services. Some of the members are here today. The funding for this project was provided by the Multicultural Access Program City of Toronto.

We were very fortunate, of course, to have recruited Rosalind Raja to help us with this assessment. Rosalind is always enthusiastic, energetic and up and running all the time. She has accomplished in three months a lot of what we have to cover in six months.

There are three parts to the needs assessment project.

1) Distribution of the questionnaire to individuals and groups. So far 200 questionnaires have been collected.
2) Interview key informants, service providers, and agency workers.
3) This health consultation will further consolidate our findings and all the results will be documented.

Before we go into the details of this afternoon's discussion, I would like to ask Dr. Perry Kendall, Medical Officer of Health of the Department of Public Health to say a few words of welcome. Dr. Kendall.

Welcome To Tamil Community Health Consultation

by Dr. P.R.W. Kendall
Medical Officer of Health

Good afternoon. I am pleased to greet you and to welcome you to City Hall. I hope that your discussions here will assist my staff in the Public Health Department, and others in social service agencies, to begin to meet the needs you identify for the Tamil Community.

The City of Toronto Department of Public Health has a proud history of working effectively with diverse cultural and ethnic groups. When the "Boat people" arrived from Vietnam, Laos and Cambodia, the Public Health Department worked with the South East Asian Community to set up a youth employment centre; to advocate for medical doctors to get internships; to translate nutrition information into appropriate languages; and to help create a multicultural health centre for Vietnamese, El Salvadoran, Portuguese and Korean speaking families.

We understand that coming to a new country - sometimes under distressing circumstances can be bewildering. But you are not alone. We're here to help you.

The Public Health Department has already hired a Tamil Home Visitor to work with the Parents Helping Parents program for isolated families, to answer their questions about raising children. We are working with our interpreter services to begin to train Tamil interpreters. And we have developed a comprehensive multicultural access policy which will guide the Department in making Public Health services available to all cultural groups.

Some of you who are participating today may not have health as your primary mandate. But you recognize that being unemployed, not being able to find affordable housing or just not knowing what social service resources are available can create stress which may affect health.

That's why we are pleased to be able to begin to identify how we can meet the needs of the Tamil community. My staff and I look forward to working with you to strengthen your community resources.

An Overview Of The Health Needs Of The Tamil Community

By Dr. Nesamoni Lysander

The "Tamil Community Health Consultation" forum, in my opinion, is a true demonstration of democracy in action regarding health care planning. This process will indeed enable us to not only have a better planning process but also to improve the quality health care now available to both the Tamil community as well as other members of our multicultural society. At the very outset, I wish to express my deep appreciation to Dr. P. Kendall and his staff for their interest and paying special attention to the needs of the Tamil community. The remarks and ideas presented here are solely based on my personal experience, observation, and the limited literature available on the subject of ethnic health care initiatives. To be effective, ethnic health care must have three basic principles i.e., community orientation, comprehensiveness, and cultural sensitivity.

Community Orientation

By community orientation, I mean that people who receive the services must have a say in where the services should be located, what kind of services are to be offered (or required), and when they should be offered. Failure to involve the community will lead to poor utilization of services. Thus, adversely affecting the health and well being of the Tamils as well as the community at large. In the context of the needs of the Tamil community, new service initiatives and modification of existing services will be more effective if the participation of people in the planning process becomes a reality. I believe, the deliberations which take place today will be become the harbinger of many positive changes in community health. Community consensus will enable health care planners to introduce new program models in community health programmes more effectively. This will enhance the efficacy of existing community-based health care system through augmented consumer collaboration and will strengthen the planning process by redirecting the scarce resources where they are needed most. Effective utilization of community health services will be made easier when the services are offered in a non-threatening manner. Ethnic groups often find many subtle barriers preventing them from using available services. They are not easily noticeable to the providers of services who are not knowledgeable in the basic belief and the background of the people.

The main threatening barriers are:

1. Organizational and bureaucratic barriers

   The number of professionals and specialities available in Toronto are quite different from what the Tamils would commonly come in contact in their home land. Many professional jargon used in everyday practice may make a person to feel inadequate to share their opinion. After all "the professionals are experts and they know best" kind of attitude may make the professionals farther and farther away from the people and their needs.

   To many Tamils, public health care practitioners such as Public Health Nurses, Public Health Educators and Nutritionists are unfamiliar health roles. Therefore, there is a need to educate them regarding the role of Community Health in Toronto.

2. Geographical barrier

   Location of services far away from the people is another barrier. Without easy access through public transportation it will be difficult for many Tamils to make use of health services. If services are not easily accessible people will tend to ignore community health services other than in emergencies.

3. Psycho-social barrier

   Many people are afraid to ask for services because they do not wish to appear to be complaining. Often they do not express their opinion because of fear of retaliation.

   They feel guilty if they have to bring their complaints to professionals who are so committed and they do not like to "rock the boat". If they do, it could mean they are not appreciative of what they have received.

4. Time barrier

   Many individuals are afraid to tell their employers they need time off to go for a health review. Moreover, if the services are offered during regular office hours many single parents and families will not utilize the community health services.

   If services could be offered in the evenings and Saturdays more people will avail themselves of such services because for most of them it is difficult to get time off from work. To overcome these and other similar barriers the silent and spoken voices of the people should be objectives for new or changing the existing programs.

   This will enable professionals to determine service priorities based on community needs and consistent with the policies of the local community health services. Giving consumers the opportunity to be heard and encouraging the people to participate by expressing their opinions and ideas will also help the healthy integration of the Tamils with the Canadian society. Resolving peoples' concerns about availability, accessibility and acceptability will enable them to participate in community health programs with a positive attitude. Removing these barriers from the minds of the people is not easy. Such attitudes can only be changed slowly. The Tamil people need help to understand that demanding services is a Canadian way of life.

Comprehensiveness

Secondly, I would like to address the issue of comprehensiveness of services. For the Tamil people, the family unit provides the most important part of support and strength to the individual. Therefore, effective community health care must provide not only services which are individual oriented but also family oriented. Within the existing community health module, I would recommend the introduction of the following:

1. Family and Personal Health Guidance and Educational Services

   Such a counselling service will assist individuals and families on:

   1. Resolving issues related to personal and family health;
   2. Communicable disease prevention;
   3. Immunization status and records maintenance;
   4. Nutritional guidance;
   5. Reproductive and sexual health counselling and treatment;
   6. Dental health - prevention, education and treatment;
   7. Personal health habits - hygiene practices, health education;
   8. Maternal and child health guidance on well women and well baby clinics, prenatal counselling and services.

2. The next area which requires attention is Environmental Health
    1. Healthy living environment at home;
    2. Health and safety at the work-place;
    3. Worker's compensation issues;
    4. Pollution and the individual's role in prevention.
3. The Third area of need is Psycho-social Health

For the Tamil people, health, illness and wellness is a social phenomena and not merely a personal responsibility. Understanding the mental health status of a refugee, a person running away from torture, the agony of settling in a new country is often difficult to be understood by a Public Health Practitioner.

Mental Health Services

Isolation, separation, and language barriers, difficulties at work all have an effect on the health and wellbeing of the person. These are commonly found among the members of the Tamil community. Working two and often three jobs is not infrequent to a person who starts a new life, wants to own a house and save enough to bring ones spouse and children over. Some have left their families to come to Canada. Loneliness strikes them severely as they are separated from their families which are the primary source of support among the Tamil people, hence the need for effective mental health services.

Family Violence Prevention

Healthy community demands healthy family life. Belief systems, ethical and family codes, personal and familial responsibility, equality of sexes, exercise of rights and freedoms are different in different cultures. When people from one culture move into another country proper orientation on family life becomes most essential for healthy integration. Providing food, shelter and basic health care is important. It is equally, if not more, important to provide emotional support for healthy family life so that the effect of food, shelter and health care can be actualized.

Providing social support is most essential to prevent spouse and child abuse. Family violence is more than physical violence. When men are exposed to the results of economic insecurity, fear and frustration sets in. Loss of social status, inequality of economic distribution and the inability to exercise political power will lead to the expression of defeat. As a result, women and children often become targets of violence. Tamil people are very susceptible in this area. To protect women from the crimes of violence, proper health education and counselling is necessary. Enabling the Tamil people to understand the value and meaning of freedom and equality of sexes must become an important aspect of community health.

Substance Abuse Prevention

Easy access to addictive substances opens the door for people to become victims of abuse. Loneliness and boredom coupled with the fear of failure make the Tamil people very susceptible to substance abuse. Therefore, an effective community health education program to prevent substance abuse must be launched in conjunction with other agencies such as the Addiction Research Foundation of Ontario.

Culturally Sound

Last but not the least, the services should be culturally sensitive. Effective health care is not possible if services are not culturally oriented and acceptable. Cultural sensitivity is very vital in all areas of health care - preventive, curative and rehabilitative services.

Reaching people who are economically disadvantaged and those from authority oriented ethnic groups is very critical for a successful community health program. Helping people to discover practical ways of resolving their cultural, economic and health crises must become the goal of a culturally sound health service.

Coming to a structured and formalised office for health care is foreign to the lifestyle of Tamil people. Relating to people in an informal manner in the family setting or in their place of work will create trust and become effective. As I mentioned earlier, neighbourhood services are more effective than services located far away from their family setting.

To reach the Tamils with therapeutic intervention and preventive health care programs it is necessary to have these services delivered in a culturally acceptable and socially supportive manner. For the Tamil people reproductive and sexual health is a very delicate matter with a strong cultural bias. Unless peoples' sensitivity is known in this area it will be rather difficult to provide guidance.

Another most common barrier is language. Cultural and linguistic expressions may lead to understating of ones intensity of suffering. Threshold of pain is quite variable among the Tamils, but generally they have very high tolerance and endurance to pain. Without knowing these subtleties it is difficult to provide optimal health care. Prevention of disease, promotion of health and health maintenance require effective communication and effective communication is not possible where a language barrier exists.

Persons from the same ethnic background and culturally empathetic will be more effective in serving the Tamil people than others. For example, many Tamil women prefer consulting a female doctor. A Tamil woman will find it extremely difficult to share her problems with a male social worker. Unless we recognize similar cultural patterns, it will be rather difficult to reach the Tamil community.

Tamil people have strong affiliation to religious identity. Culturally, they would seek help through religious institutions. It will be beneficial if educational programs on community health could be introduced through appropriate religious bodies. For example, if a religious group organizes a gathering, a Public Health Educator could speak on family life, nutrition, substance abuse, etc.

Summary

Effective community health care planning requires participation from the ethnic community - the Tamil community. Community Health Services ought to be community oriented, comprehensive and culturally sound. The Toronto Department of Health is moving in the right direction. Cross-cultural health care is a challenge. Recognizing the uniqueness of this service is the beginning of the success of this venture.

Reference: Multiculturalism, Medicine and Health by:
Dr. Ralph Masi, 1017 Wilson Avenue, Suite 406,
Downsview, Ontario.
M3K 1Z1.

After the Door Has Been Opened. Report of the
Canadian Task Force on Mental Health Issues Affecting
Immigrants and Refugees.

Social Service Needs Of The Tamil Community

By Reetha Parthiban

Background - Ontario Welcome House

Ontario Welcome House operated by the Provincial Ministry of Citizenship is a place where new immigrants and refugees can receive free and confidential counselling on how to adapt to their new home. The mission of the Ontario Welcome House-Network is:

- To provide direct multilingual, multicultural settlement services to newcomers and others who, for whatever reasons, have difficulty accessing services in English;

- By providing information, referral and counselling;
- By facilitating access to services at all levels by networking with local service providers;
- Acting as a resource to community and general public;
- Identifying and reporting on an ongoing basis, areas of need, gaps with the settlement and community services.

Background - Sri Lanka

Sri Lanka is separated from India by 43 kilometer-wide Palk Strait. Sri Lanka was colonized by the Portuguese in 1505, the Dutch in 1602 and the British in 1795. The British imported labourers to Sri Lanka from S. India to work on the tea plantations. Sri Lanka gained independence on February 4th, 1948.

Political Background

After the Independence there has been an ongoing ethnic violence between the Sinhala and the Tamils, 2.5 million Tamils live in the North (Jaffna) and in the East Balticola. The majority are the Sinhala and the minority are the Tamils.

Religion

Most of the Sinhala are Buddist and some Christians whereas most of the Tamils are Hindus, the others are Christians and Muslims.

Refugees

After the ethnic riots of 1956 many middle class professionals immigrated to Canada. Since 1983 the ethnic conflict which has ravaged Sri Lanka has led to the flight of nearly 200,000 Sri Lankan Tamils to India and other countries.

On September 1983 the Canadian Government implemented a policy of non-removal of Sri Lankan Tamils to their home country.

Population of Toronto

When we consider the population of Toronto today, we are immediately struck by its unique racial diversity. Recent Immigration statistics reveal that more than 25 percent settled in Metro Toronto. There is a tremendous rate of secondary migration towards Ontario. Due to this diverse population, the social services have to continuously change to adapt to the people that they serve.

In recent years the influx of immigrants to Toronto has also affected the social service needs in the suburbs like Scarborough and Etobicoke.

Social Services

The Social Services that are currently available are those related to physical health, mental health, community centres, information services, supportive services and others. However, recent research has shown that there are several barriers that different ethnic groups experience.

Language Barriers

Many refugee claimants and immigrants face language barriers. English is their second language. Some have basic command and others have to learn a new language. This limits access to several social services. Hence a multilingual setting is necessary to serve this diverse population.

Information Barrier

The public are unaware of the services that are available. Though many pamphlets are translated into various languages, it does not reach the people who need them the most.

The ethnic media and the general media should be used to disseminate this information to the community, hospitals, doctors, schools, etc.

Cultural Barrier

Many newcomers don't seek outside assistance because it is a new concept to have such effective social assistance programs. Outreach should be initiated to various ethnic communities to make them aware of the services that are available e.g., to apply for financial assistance (welfare) or seek help for mental health is something which is totally a new concept. South Asian cultures stress harmony in interpersonal relationships and value suppression, repression and denial as methods of handling negative feelings. If the cultural beliefs and values are not understood, to solve interpersonal problems would be difficult.

A central data base should be available in order to facilitate communication and its existence should be publicized in order to avoid repetitive research.

Staffing Barrier

Social service agencies are not adequately staffed by representatives from various ethnic communities with the result that many newcomers especially those with language barriers don't have access to those services.

Board Representatives

The Board should also reflect the diverse population. Active recruitment should be done through community agencies. Volunteerism is a new concept so the ethnic communities should be encouraged and educated about volunteerism.

Other Social Trends and Needs

Housing

Due to lack of affordable rental housing in Metro Toronto, many newcomers face great hardship. They are forced to rent rather expensive furnished apartments or substandard basement apartments. Many live in crowded conditions; often the entire family sleep in one room until they are able to find affordable housing. This is a serious cause for health hazards and it also has direct bearing on how children perform at school. Being a refugee claimant, it is almost impossible to rent an apartment without proper documents and references.

Daycare

Women find it difficult to compete in the labour force due to lack of subsidized daycare. There is a long waiting period and they are unable to coordinate employment and daycare together. Hence it is the women who are isolated from the community because they have to stay home with the kids.

In Scarborough, there is a greater need for English as Second Language (ESL) classes with nursery facilities.

Education

The school system is rather different from that in Sri Lanka. There, they have clearly defined rules and regulations. Students are not encouraged to question the teacher which is considered as confrontation. Parents place great emphasis on education. It takes time before the students can actively participate in group discussion and initiate their own ideas. There is a greater need for English as a second language classes. They should develop a buddy system where the students from the mainstream should help them assimilate into the mainstream.

Disabled

Among the refugee claimants there is a significant number who have been disabled due to wars in their homeland. This group is at a great disadvantage because they cannot access to various rehabilitation services until they are landed.

Family Violence

Family violence is on the increase. There is a lot of stigma attached to seeking help outside the family. A lot more information sharing should be done within the community to make people aware about what is available.

Public Health Nurses

Public Health Nurses should have access to multilingual video tapes which they could encourage mothers to view about various topics e.g., prenatal care, postnatal care, how to dress-up in winter or general information as to apartment living.

Family Structure

Many come from extended families with a hierarchy of power. Grandparents are usually the oldest and so most of the time they are involved in decision making. Mothers usually concentrate on the child's educational needs and stay home with the kids. The grandparents play a very important role in the upbringing of the grandchildren. This family structure is reversed when they come to Canada because the elders start depending on the children to communicate their thoughts due to language barrier. Mothers start working and this seems to unbalance the security that they had at home. Here, they have to learn how to look after themselves and care for their siblings. There is a great need for helping teenagers to adapt to this system and to maintain their culture.

Pre-Immigration Status

Pre-immigration status is very important because this will explain why there is so much difference among the newcomers. They may either come from rural environment or from urban environment. There is also a large group who have lived outside Sri Lanka either in England, Africa or United States. Depending on their pre-immigration status their needs are different and the performance of their children is also different. The longer they have been away from their country, their traditional values and customs are altered to adapt to the new environment. People who have been here for a longer period may get offended by close identification with their homeland and stereotype assumptions.

Conclusion

I would like to congratulate the City of Toronto Public Health Department in taking this initiative to organize the First Tamil Health Consultation. I am proud to be part of this consultation. This is a positive step in coordinating the link between an ethno-specific organization (Sri Lankan) and the mainstream. The City of Toronto already has to its credit, the first to hire a Parent-Helping-Parent Program Worker and also a Tamil Health Promotion Worker.

From this consultation, I feel very positive that we will not stop at only identifying barriers but also bring down those barriers.

Maternal And Child Care Needs

By Dr. Raji Thuriarajah

I have been practising as an Obstetrician and Gynecologist in Queensway General Hospital in Etobicoke for the last two years. During this short period I have noticed an increase in the number of Tamil patients in my practice. Some of them come all the way from the East End mainly because of the language barrier and they feel I can relate to them better.

Today I'd like to share with you three major problems these Tamil patients are faced with in Canada.

Namely,

1. Language barrier
2. Cultural differences with regard to Maternity Care and Child Care.
3. Lack of knowledge of the resources available in the community.

Let us first look at the language barrier

Most of these patients are refugees. Although they are from different socio-economic backgrounds, there is one common problem - the language barrier. The majority of these people are educated only in Tamil medium and very few come from homes where English is spoken.

This lack of English knowledge precludes proper communication and as a result they are isolated and they tend to confine themselves to their own friends and relatives. Language barrier is a major problem in securing suitable jobs. They are unable to utilize their skills and this leads to frustration as most of the women are forced to stay at home which leads to further isolation.

Cultural Differences With Regard To Maternity and Child Health

It is important for us, the health care providers, to understand the cultural aspects in reference to pregnancy, labour and delivery and child health, so that we can appreciate their difficulty and help them to adapt to the new culture in Canada.

I'd like to briefly review some of the basic concepts in Sri Lanka. Although the majority of deliveries take place in hospitals under medical supervision the midwives do play a major role. All normal deliveries are conducted by the midwives in the hospital. Certainly a number of home deliveries still take place in some of the remote villages. They are conducted by the untrained midwife who is usually an experienced senior member in the community.

Well organized prenatal care is provided in all the hospitals but they are not utilized by all pregnant women. There are many reasons for not seeking medical care during a normal pregnancy. "Pregnancy is considered a normal event and not an illness." Experienced senior members in the family such as grandmothers, mothers, aunts, etc., play a major role in the care of a pregnant woman. The majority of these people have extended families and they all live very close to each other. A pregnant woman is given a special status in our community. She is usually pampered by the society in general.

Their prenatal education is mainly on a day-to-day basis offered by the senior members of the family referred to earlier. In addition, there are trained midwives who do home visits and they provide some basic information.

Labour and Delivery

This is always a female domain. The obstetrician only supervises the labour and delivery, and gets involved only if there is a complication. Fathers stay far away from the labour and delivery area and they are not expected to play an active role. "Fathers are there only to provide for the child."

After delivery when they return from hospital they are again pampered "if I may say." The extended family and the friendly neighbours take over the care of the mother and the baby up to at least a month. Midwives do post partum home visits up to two weeks.

Patients who come from such a background to Canada - sometimes wonder why they have to see a doctor so many times during their pregnancy especially those who have had children before. They ask me "Should I come every week, Doctor?"

On the other hand, the first time mothers are scared because they have no extended family here, to turn to for advice or help. So they depend on the doctor and the health care workers in the hospital. Unfortunately, there are not too many Tamil-speaking health care personnel they can turn to.

Recommend

Until such time these patients integrate into Canadian society and learn to speak English, we need to provide them with adequate prenatal education in Tamil.

Unlike us average Canadians, these patients do not have any basic knowledge of human anatomy or physiology of human reproduction. This makes it very difficult for them to understand and it is equally difficult for us, the health care personnel, to get the information across to them.

They are used to accepting whatever the doctors say as the final word and they do not question - "Doctor knows best" and they expect you to tell them what to do - so when you try to get them involved in decision making, they cannot understand why you are asking them to make a decision. "Doctor, whatever you think is best."

Recommend

Time of labour and delivery is very traumatic to the woman and the husband, especially the first timers. The husband who is kept away from the pregnant woman is now forced to coach the wife in labour and witness the delivery of his baby. With no prior knowledge of labour and delivery, to perform the function of a coach and be present at delivery is a very trying experience for a new father. Therefore, prenatal classes for the couple, not only for the woman, is a must.

Child Health - Early - Up to 1 year

From 1 year to school age

It is obvious that feeding, clothing and health needs of a child are very different in Canada compared to Sri Lanka. Information regarding these facts should be provided well in advance ideally during the prenatal period.

The same facts I alluded to earlier regarding pregnancy, apply to child care too. When a baby is born, the whole family take part of the support care - both physical and emotional.

In the absence of such a family support the mother here is left alone to cope with the new baby. Her problems are compounded by the language barrier.

At present they get some information during their post partum period in the hospital from the doctor and nurses. Thereafter, the Family Physician or the Pediatrician is the only source of information.

Now with the policy of early discharge from hospital even the English-speaking Canadians are finding it difficult to cope with the new baby.

We need to provide home visits by health care personnel i.e., a Public Health Nurse to help the new mother. However, occasional visits by a nurse is not enough. They need more support. How can they get this support?

I recommend we should help them to organize self-help groups similar to a wide range of them that exist in many areas. By forming such groups, they can exchange their own problems and learn from each other.

a) A counselling service should be organized, utilizing health care personnel and members of the community;

b) Provide a hot line;

c) Self help groups - these are morale boosters and provide help to members in coping with particular circumstances.

These people, who are new to Canada, are not aware of the many resources available to them. To name a few - Community Centres, Multicultural Assistant Services, Church groups, Catholic Aid Society, Well Baby Clinics, Crisis Centres, Women's Shelters, etc.

We should provide a central information centre in Tamil which can be used to provide and direct them to the correct resources to suit the needs of the patient.

In conclusion: Recommend

- Providing information in Tamil;
- Education of the patient in Tamil; i.e., prenatal, postnatal, Well Baby care, etc.
- Encourage them to start learning English as soon as possible;
- Self Help groups.

They should be encouraged to integrate into Canadian society and discouraged from secluded communities. The key to integration is communication which means breaking the language barrier.

Encourage them to learn English.

Mental Health Needs Of The Tamil Community In Toronto

By Dr. Janaki Srinivasan

I am extremely pleased to be with all of you here to share my experiences and views, which may be of some help in serving the needs of the Tamil Community.

I have been involved in serving them at various levels such as: in-patients in the general and psychiatric hospital, out-patients referred to my office from different sources such as Canadian Centre for Victims of Torture, Riverdale Immigrant Women's Centre, the school system, from colleagues, also voluntary referrals, etc.

In my practice, as well as in general, there seems to be a definite steady increase in the proportion of this group, either as a result of increased awareness of resources available or inability to cope with demands of the society, such as stress, etc., which makes them to seek help in order that they may be able to better handle their life in Canada.

The common factors seem to be as follows:

1) cultural shock;
2) financial hardship to maintain a suitable standard of living;
3) climatic conditions;
4) language barrier;
5) facing the stigma of being a refugee in Canada;
6) sense of alienation due to a feeling of losing all their ties with their homeland to start a new life;
7) the discrepancy in their expectations and actual accomplishments.

The majority of them still live in larger groups lacking proper accommodations, etc. In addition, they are isolated from other ethnic groups, which prevents social adjustment to their living in Canada. Incidence of domestic violence, physical abuse of spouse and children has been noted. The predominant theme underlying these appears to be marital dysfunction in several cases. After initial assessment, this group is most difficult to deal with in terms of offering treatment or therapy, as either the husband or wife often do not cooperate or follow through the recommendations of the Doctor. On certain occasions health care workers have gone to the extreme of bringing them to the office to seek treatment for several weeks. This is neither a desirable way or a practical way of giving health care to this population. Hence, alternate methods of helping these victims should be identified which may be in accordance with their cultural beliefs. Basis for marital dysfunction appears to be lack of financial support, alcoholism in the spouse and occasionally insecurity in the marital relationship.

The type of patients encountered are often adult male and females, also teenagers such as adolescent males or females.

Among the most common mental illnesses seen are depression of different types, post-traumatic stress disorder with anxiety and depression, secondary to their traumatic experience in their life in Sri Lanka. Psychotic illness such as Schizophrenia, a paranoid disorder which often manifests after migration to another culture, where the individual experiences difficulty in coping with conflicting needs and demands. Alcoholism appears to be a striking problem associated with depression. However, this group often is highly resistant to treatment suggestions and often are very hesitant to seek any guidance. Children appear to experience behaviour problems in adjusting to the school setting. Handicaps in learning the English language, cases of mental retardation, and learning disabilities have been identified.

Parents of this group are once again unwilling to accept the identified problems and believe in fatalistic theories. They tend to undermine extra help offered and are unrealistic with their expectations. The majority of the people I have seen are physically healthy, active, and quite willing to work. A few cases of very young males have been diagnosed to be suffering from heart problems such as chest pain with increased stress, tension, etc. I have been called on occasions about patients suffering from cancer, etc. who have been isolated with lack of support in hospitals. Most often, these people lack any other resources of social interaction in groups, other than watching T.V., or movies in their native language, and attend religious activities which may not help them to adjust to the setting and environment in which they live. Some of them are very keen to learn English and often attend evening classes.

Interesting enough, although they have financial problems, members of this group are unwilling to consider work offers such as housekeeping, babysitting, etc. They tend to like factory work and feel most prestigious working outside their home. This may be in keeping with cultural complexities and tendency to undermine the financial gain and inability to appreciate such demands and needs. This may not only improve their financial situation but has scope to improve their educational needs and career oriented training, etc.

In my final conclusion and remarks, I wish to state that the reason for failure to seek help for various needs are due to lack of sophistication in help seeking efforts in addition to stigma of having mental illness which is culturally and society based. They tend to view the hospital as a sick place and deny their problems to a very large extent. Most often appointments are missed, whereabouts cannot be located as they tend to move around. Their lack of concern regarding physical and mental health problems need greater attention to reintegrate into the community.

Compared to ten years ago, support for multicultural groups has improved to a high degree. The Canadian government is very sensitive and supportive of the needs of various ethnic groups. However, in order to improve serving this group, perhaps the following additional recommendations may be considered such as:

1) The Department provide staff time using a community development approach to assist Tamils living in St. James Town and other areas in developing appropriate health services/programs.

2) The Department reallocate funds to allow for flexibility to hire contract staff who will be able to help any new community to assess, organize and develop appropriate health services/programs.

3) The Department approach external sources of funding to hire staff to work with this community's health needs.

4) The Department, in collaboration with the City's Multicultural Access program, develop a protocol to assess and facilitate health services for new arrival refugees/immigrants based on the experiences learned from the Tamil and South East Asian communities.

5) The Department request the Access Alliance to train and include Tamil interpreters in their pool of interpreters.

6) The Department translate pamphlets on key issues into Tamil in consultation with Tamil associations and work with these associations to distribute translated materials.

7) The Department in association with the Tamil community sponsor a "Health Fair" or other promotional campaigns to raise the Tamil community's awareness of health issues and programs.

8) The Department examine appropriate options to develop and implement new or expand existing programs that respond to the community's immediate need for prenatal and parenting programs.

9) The Department investigate the possibility of upgrading skills of Sri Lankan qualified health professionals through training opportunities.

10) The Department disseminate this report to other relevant agencies and organizations.

Appendix E

Tamil Community Health Survey

List Of Agencies/Individuals Who Assisted With Distribution And Collection

Tamil EELAM Society of Canada

S.A.C.E.M. (Society for the Aid of Ceylon (Sri Lankan) Minorities)

Tamil Co-op Homes

Tamil Christian Church of Canada

Tamil Catholic Community

Tamil Senior Centre

Tamil- E.S.L. Teachers

Tamil - Heritage Language Teachers

Refugee Information Centre

Tuxedo Court Apartments

Receptionist for Dr. Elizabeth George

Receptionist for Dr. Francisco Portugal

Coding - Janaki Srinivasan

Analysis and Tabulation - Chee Wong, Health Promotion and Advocacy Section, Department of Public Health

Tamil Community Health Survey

September - October, 1989

This survey is designed by the City of Toronto Department of Public Health to assess the health needs of the Tamil community living in Toronto. No name is necessary and all information given will be kept very confidential. Thank you for your co-operation.

A. Age ____ yrs.

Sex ___ M/F

Marital Status: _______ Single/Married/Widowed/Separated

Language Skills: _______ Tamil/English/other - specify

Residence Area:

City of Toronto ___	North York ___	Scarborough ___	York ___
East York ___	Etobicoke ___	Mississauga ___	Other ___ (specify)

Year of Arrival in Canada: 19___

B. Health - Medical

1. Do you have O.H.I.P.? Yes ___ No ___
2. A family doctor? Yes ___ No ___

If the answer to 1 and 2 is yes please answer question 3.

3. How often would you visit your doctor?

   Regularly ___ Periodically ___

   As the need arises ___

If the answer to 1 and 2 is no please answer question 4.

4. What is your reason?

   I do not know where to go ___ whom to contact ___

   No time ___ Other ___

5. What medical services have you used so far?

   Hospital ___ Out-patient department ___

   Emergency ___ Clinic ___ Private doctor's offices ___

6. Do you have a dentist? Yes ___ No ___

   If yes:

   How often would you use the services of a dentist?

   Regularly ___ Occasionally ___

   As the need arises ___

   If no skip to section C.

C. Health Information

Obtaining Public Health information on the Following Topics was:

	Easy	Difficult
1. Having a Baby	___	___
2. Raising Children	___	___
3. Dental Health	___	___
4. Nutrition	___	___
5. Infectious Diseases	___	___
6. Immunization	___	___
7. Birth Control	___	___
8. How to Quit Smoking	___	___
9. Alcohol/Drugs	___	___
10. Stress and Emotional Problems	___	___
11. Sexually Transmitted Diseases	___	___
12. AIDS	___	___

13. Elderly Persons Health ___ ___

If obtaining health information was difficult identify the reasons:

___ Too afraid to ask

___ Did not know how to go about it

___ Pamplets not available in my language

___ Lack of interpreters

___ Lack of time

D. Risk Factors

Have you ever been told by a doctor that you:

are overweight ___yes ___no

have high blood pressure ___yes ___no

have heart trouble ___yes ___no
(heart attack/angina/rheumatic heart disease)

have Arthritis/Rheumatism ___yes ___no

have Asthma ___yes ___no

have chronic depression
or anxiety ___yes ___no

have Anaemia ___yes ___no

have Diabetes ___yes ___no

Other - specify ___________

E. Housing

1. What type of housing are you living in now:

   ___ Rented room

   ___ Apartment

   ___ Basement apartment

   ___ Condominium

   ___ Single family dwelling

2. Do you ___ own ___rent.

3. Are you living ___ alone ___ with family

4. Do you feel the place you are living in is:

   ___ Adequate ___ Crowded

   ___ Well heated ___ Cold

   ___ Well ventilated ___ Poorly ventilated

F. Employment

1. Do you have a job? ___Yes ___No

2. How did you obtain that job?

___ Through family ___ Friends

___ Fellow Countrymen ___ Employment agency

___ Newspaper ad

___ Other - specify __________

3. How long did it take you to obtain your job?

___ Immediately (1-2 months)

___ Not very long (3-6 months)

___ More than 6 months

4. Does your job give you satisfaction?

___ Yes ___ No

5. Do you work ___days ___nights

6. Do you work ___ 8 hour/day

___ overtime

___ weekends

7. Are you aware of your:

occupational safety rules? ___ Yes ___ No

occupational health hazards? ___ Yes ___ No

8. As a newcomer list some concerns you might have about your job:

a. ______________________________

b. ______________________________

c. ______________________________

d. ______________________________

e. ______________________________

G. Support Systems

1. Do you have adequate support systems? ___ Yes ___ No

2. Who are the people you might turn to for support:

___ Parents

___ Family

___ Friends

___ Elders in the community

___ Priest

___ Minister of the church

___ Tamil organizations

___ Welcome House

___ Family Doctor

___ Public Health Nurse

Thank you.

If you have any further questions you may call Mrs. Rosalind Rajanayagam, Public Health Department, Community Health Promotion and Advocacy Section at 392-6620 extension 16.

APPENDIX F

ONTARIO WELCOME HOUSE (MINISTRY OF CITIZENSHIP) SERVICES PROVIDED FOR TAMIL CONTACTS BY REETHA PARTHIBAN SETTLEMENT OFFICER FOR 1989

TYPE	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
ORIENTATION	201	245	200	306	375	386	276	121	316	273	336	168	3203
IMMIGRATION	242	142	177	329	477	439	203	92	289	320	357	530	3597
HOUSING	4	21	12	19	11	13	21	1	–	14	3	7	126
EMPLOYMENT	57	230	329	305	370	373	141	78	281	285	90	194	2733
EDUCATION	140	170	359	258	218	318	180	71	251	250	309	171	2745
HEALTH	92	13	451	325	347	512	317	11	213	260	253	292	3086
LEGAL	351	109	89	177	168	168	90	31	142	174	279	132	1910
TRANSLATION	16	17	19	15	6	12	13	20	–	15	–	6	139
FINANCIAL	145	149	197	192	216	202	217	56	93	167	221	242	2297
PERSONAL	3	3	16	3	3	9	3	–	3	3	–	3	49
TRANSPORT	18	3	40	15	14	4	4	2	–	15	12	16	143
COMMUNITY SERVICES	393	116	116	312	303	213	107	111	300	279	336	177	2763
CHILDREN	22	13	16	–	3	21	9	9	3	15	26	–	117
TOTAL	1934	1231	2021	2256	2511	2670	1581	603	1891	2070	2222	1938	22928

Appendix G

Tamil Resources

The Ontario Welcome House,
4439 Sheppard Avenue East,
Scarborough, Ontario. M1S 1V3

Telephone: 965-9902

The only Tamil Settlement Officer works from Scarborough. New arrivals are given help with obtaining S.I.N., O.H.I.P. as well as information on E.S.L. classes, daycare, housing, etc. The initial support Tamils receive from the Ontario Welcome House is tremendous.

The Tamil EELAM Society of Canada, 310 Danforth Avenue, Room 14, Toronto, Ontario. M4K 1N6 Telephone: 463-7647

The Tamil EELAM Society of Canada has been providing information and referral services on an informal basis since 1972. The Society has also made representation to the Federal Government on behalf of the Tamil refugees, as well as organized heritage language classes and cultural activities. They run a telephone hotline 24 hours a day, 365 days of the year. A recent I.S.A.P. grant from the government has enabled them to offer settlement services on a larger scale than before as well as appoint full-time office staff to serve the Tamils better.

The Hindu Temple, 10945 Bayview Avenue, Richmond Hill, Ontario. L4C 3P2 Telephone: 883-9109

The Hindu Temple serves over 3,000 Tamil members who belong to the Hindu faith. The temple located in Richmond Hill was first planned for in 1972. Completion of the present temple and formal opening was in 1983. There are five residential priests who officiate at weddings, first hair cutting ceremonies, ceremonies to mark the introduction of solid foods to babies as well as many special occasions. On Fridays, and on special holy days the temple is open to devotees till late. A board of 19 trustees oversee the administration of the temple.

S.A.C.E.M., Society For The Aid Of Ceylon-Sri Lanka Minorities), c/o The Oriole Community Resource Centre, 2975 Don Mills Road, North York, Ontario. M2J 3B7

The Society for the Aid of Ceylon (Sri Lanka) Minorities is a registered charitable organization whose mandate is to offer initial assistance to Tamil refugees. S.A.C.E.M. was established in 1983 after racial riots in Sri Lanka. S.A.C.E.M. initiated a co-op housing proposal, which a group of elected Tamil directors carried out, with funding from the Federal and Provincial governments and guidance from LANTANA, non-profit housing consultants. S.A.C.E.M. is at present engaged in a demographic study of the Tamil community.

Tamil Co-Op Homes, 20 Wade Avenue, Toronto, Ontario. M6H 4H3 Telephone: 538-6015

A 149-unit Co-op Housing was built on 20 Wade across from the Lansdowne subway. 80% of the occupants there are Tamils. Several of the units at the Tamil Co-op Home carry a subsidized rent to enable newcomers to obtain affordable housing. One 4-bedroom unit in the building is run by S.A.C.E.M. as an emergency shelter for Tamils on a short-term basis.

The Tamil Christian Church of Canada, c/o Dr. N. Lysander, 38 Kathrose Drive, Willowdale, Ontario. M2J 3P3 Telephone: 493-7100

The Tamil Christian Church which was officially begun in 1986 operates from West Ellesmere United Church in Scarborough. Two Tamil services are held in a month, on the 2nd. and 4th. Sundays at 4 p.m. An elected Board of Directors along with an ordained part-time Tamil minister serve the Tamil Christian population with their spiritual needs. The members share the expenses.

Tamil Catholic Community of Toronto c/o Father Patrick Gnanapragasam, 16 Lockwood Road, Toronto, Ontario. M4L 3M8 Telephone: 363-4018

The Tamil Catholic Community of Toronto was begun in 1989 to meet the spiritual needs of Tamils who belong to the Roman Catholic faith. Promoting social, recreational and education programs, as well as offering scholarships, and bursaries for advancement in religious, scholastic and athletic achievements, are some of their key objectives. Leadership is provided by a volunteer committee of ten, and the group functions under the guidance of the Roman Catholic Archbishop of Toronto. Worship services are held at 4:00 p.m. every Sunday at St. Maria Gorretti Roman Catholic Church, 717 Kennedy Road, Scarborough, Ontario.

Senior Tamils' Centre, c/o The Oriole Community Resource Centre, 2975 Don Mills Road, North York, Ontario. M2J 3B7 Telephone: 467-5830

The Senior Tamils' Centre was opened in September 1985 to meet the special needs of Tamils over the age of fifty five. The object of the Centre is to promote cultural, social and recreational activities for the Tamil Seniors living in Metro Toronto and Greater Metro.

The activities include an annual subsidized educational field trip, group discussions, regular "Bridge" tournaments and occasional religious and cultural day celebrations. A drama club has also been formed to encourage seniors to the stage. The Centre issues an informative quarterly journal to its members.

The "Bridge" club of the Centre meets at the Oriole C.R.C. on Thursdays from 6:00 - 10:00 p.m. and on Saturdays from 2:00 - 8:00 p.m.

The Centre is partly funded under the "New Horizons" program. An elected board of eleven members presently headed by Aloy Ratnasingham runs the Centre.

Contact person is the Centre's Secretary, Siva S. Nathan 467-5830.

Appendix H

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The Board of Health also submits the written presentation from Dr. R. Thurairajah:

First of all I thank you for giving me this opportunity to express my concerns regarding some of the health problems among the Tamil community.

As an Obstetrician and Gynaecologist I confine myself to the following four aspects:

a) Pre and Post Natal Care b) Infant and Child Health c) Family Planning d) Sexually Transmitted Diseases

The main problems I recognised in providing the above services are:

1. Language barrier.
2. Cultural differences and attitudes towards pregnancy and child birth, family planning and sexually transmitted diseases.

3. Lack of basic knowledge regarding the above mentioned items.
4. Inability to utilize the resources available in the community - once again due to the language barrier.

I need not emphasize to this audience, break down in communication due to language barrier is the main problem faced by new immigrants.

Lack of communication leads to isolation and frustration.

Cultural differences and attitude with regard to maternity and child care, family planning and sexually transmitted diseases, are so conservative and entirely different from what we Canadians are accustomed to.

Child birth is mainly a family affair dominated by the female members of the community. Males keep a distance. Tremendous family support is provided during pregnancy, which is not available here to the new immigrants. Therefore, they need help and support from us the health care workers. As the husbands are not accustomed to taking an active part in child birth, they are equally at a loss in helping the new mother.

Attitudes towards family planning is also different. It is not a matter that is openly discussed partly due to lack of knowledge and partly due to the personal and private nature of this aspect. Anything related to sex is not discussed in public.

The same applies to STDs. The word sex is not mentioned in public, and anyone contracting and STD is a social outcast. STDs are associated with immoral behaviour. Therefore, it is not easy to openly discuss these topics.

Recommendations:

1. Provide Tamil speaking health care workers, e.g., public health workers and Tamil interpreters.
2. Educate re: pre and postnatal care child health, family planning and STD through health care workers, media (Tamil program available in Radio, TV) Tamil brochures, etc.

   A pilot project is underway to start Tamil Prenatal classes at Queen Elizabeth Hospital by the Toronto Board of Health. A Tamil nurse has been hired to be trained to conduct these classes. If this is successful, we should be able to expand these classes to other areas of Toronto.
3. Education in Family Planning and sexually transmitted diseases should be at all levels from doctors offices to the media and brochures.
4. Organize self help groups in the community.
5. Provide a hot-line through the central information centre in Tamil.
6. Set up a counselling service through the community.
7. Encourage the immigrants to learn English and integrate into the Canadian society and prevent isolation.

The Board of Health also submits the communication from S. Sellathurai:

I fully endorse the statement made by Maria Lee, the Supervisor of the Health Promotion and Advocacy Section, Department of Public Health in her introductory speech on November 27, 1989, about Mrs. Rosalind Rajanayagam.

I read through the report and I could say that the Assessment Project was very well completed. This was the first of its kind about the Tamil community and the information contained therein is useful and valuable for any follow-up action.

(1) Dr. N. Lysander in his "Overview of Health Needs", (2) Ms. Reetha Parthiban in her "Social Services and Community Needs", (3) Dr. Raji Thurairaj in her "Maternal and Child Care Needs"; (4) Dr. Janaki Srinivasan in her "Mental Health Needs" - have fully recognized and described the needs of the Tamil Community in Toronto and have stated how these should be worked out. We

should be very thankful to them for the valuable information they have provided. These suggestions and recommendations should be put to test fearlessly, to be "Happy to be Alive".

We should be also grateful to Dr. P.R.W. Kendall, Medical Officer of Health for his encouragement in his speech he said "You are not alone. We are here to help you ... My staff and I look forward to working with you to strengthen your community resources".

I therefore suggest that this report, as it is, be adopted and printed in the form of a handbook for the information of the Tamil population in Toronto.

The following are my personal suggestions for your consideration for the future working of the needs of the Community.

1. Set up a Central Board.
2. Action to be area-wise (divide Metro-Toronto into 4 to 5 divisions).
3. Get the service of interpreter/translators (this is very important - mention is made in all presentations).
4. Obtain the services of male doctors also.
5. Education - English as a second language and English skills development.
6. Counselling on Family Life, Drug Abuse, Housing, etc.
7. Many immigrants underwent much persecution in Sri Lanka. As such, they are affected mentally and physically. (Think of the children born to them).
8. Health Department should have the fullest contact and cooperation with the Employment and Immigration and the various Boards of Education in Toronto.

The Board of Health also submits the communication from Fred V. Balasingham, President, Senior Tamil's Centre:

One shortcoming perceived and reported by the key informant under Health Utilization Pattern of the Tamil Community was - a dentist is visited only when an emergency arises and not on regular basis.

It would appear that the reasons for not visiting a dentist by the Tamils, especially the Tamil seniors, is not the lack of knowledge in dental education. The real reason is the high cost of dental care. Any one covered by dental plan can afford to see a dentist at regular intervals, but a high percentage of Tamil employees who are not covered by a dental plan, especially the Tamil seniors, can ill afford to see a dentist, because they depend on their children and it would add a lot more of financial strain on their children. In Sri Lanka, dental care was always free and available at all civic hospitals.

Respectfully submitted,

JACK LAYTON,
Chairman.

COUNCIL CHAMBER,
Toronto, October 25, 1990.